

**Understanding of the Use of Alcohol in Pregnancy  
Amongst Women in Scotland**

**Thesis submitted in accordance with the requirements of the  
University of Liverpool for the degree of Doctor in Philosophy by  
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## **Abstract**

### **Understanding of the Use of Alcohol in Pregnancy amongst Women in Scotland Katharine Jane Ford**

This thesis examines the use of alcohol in pregnancy amongst women in Scotland, post the introduction of a recommendation for abstinence in 2007 from alcohol during pregnancy. There is an ongoing debate over this recommendation, with some researchers highlighting abstinence as the safest choice but others indicating that such advice may generate excess fear and stress to mothers and can also be a way of stigmatising and controlling women. I argue that an increase in women's alcohol consumption has also initiated a marked increase in attention towards the role of alcohol in women's lives and the risks of drinking alcohol during pregnancy. This growing emphasis of the concern towards women drinking during pregnancy has come from the extension of the medicalisation of motherhood and the perception that the maternal-foetal relationship is strained.

Biographical narrative interviews with 22 women in Edinburgh and Inverness are used to explore women's alcohol consumption during pregnancy in Scotland. Primarily with the aim to further the understanding of the social and cultural context of women's alcohol consumption during pregnancy by examining women's attitudes towards drinking during pregnancy and their awareness of the risks of consuming alcohol during pregnancy.

It is my contention that there are many complex themes involved in women's choices around drinking during pregnancy and that the change to abstinence has further led to the messages women receive being inconsistent, which leaves women in a state of confusion. I maintain that it is important that we recognise that women have different attitudes towards alcohol. Women cannot associate themselves with generalised statements about harm and risk. I explore how women respond to health interventions and their attitudes towards existing public health campaigns and health interventions. Consequently, I contend that women in this study reveal mixed attitudes towards these interventions as they often feel they gloss over the individuality of these decisions and their complexity within women's lives by using a 'one size fits all' approach. Women therefore challenged the notion of harm and the evidence base behind the guidance, leading to a lack of confidence in the medical profession and an increasing reliance on lay health beliefs. It also draws upon the often overlooked importance of pleasure in women's choices around alcohol consumption. The study highlights the importance of women's experience, and the necessity of talking to women to further understand what influences their decision making around alcohol consumption during pregnancy. I argue that an attempt to trigger concern in pregnant women is inappropriate because of the lack of evidence into the risks caused by even moderate alcohol consumption.

## **Dedication**

I would like to dedicate this work to the memory of my beloved friend Carly Harper and her baby who tragically passed away whilst I was completing this research.

Thank you for sharing your laughter, love, endless support and words of wisdom throughout our 20 plus years of friendship. You and your baby Boo will live on forever in my heart. You are sorely missed by everyone who knew you.

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## **Declaration**

This thesis is the result of my own work. The material contained in the thesis has not been presented, nor is currently being presented, either wholly or in part for any other degree or qualification

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## List of Acronyms

AARBEs	Alcohol-Abuse-Related Birth Effects
ABI	Alcohol Brief Intervention
ARBD	Alcohol Related Birth Defects
ARND	Alcohol Related Neurodevelopmental Disorder
BBC	British Broadcasting Corporation
BCCEWH	British Columbia Centre of Excellence for Women's Health
BNIM	Biographical Narrative Interview Method
CDC	Centres for Disease Control and Prevention
CMO	Chief Medical Officer
DOH	Department of Health
ESRC	Economic and Social Research Council
FAE	Foetal Alcohol Effects
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
GP	General Practitioner
GUS	The Growing Up in Scotland Survey
IVF	<i>In Vitro</i> Fertilisation

MI	Motivational Interviewing
NHS	The National Health Service
NICE	The National Institute for Health and Clinical Excellence
NOFAS	The National Organisation on Foetal Alcohol Syndrome
PFAS	Partial Foetal Alcohol Syndrome
PRAMS	Pregnancy Risk Assessment Monitoring Systems
SEC	Socio-Economic Classification
SES	Social-Economic Status
SQUIN	Single Question Aimed at Inducing Narrative
TQUIN	Topic Questions Aimed at Inducing Narrative
UK	United Kingdom
USA	United States of America

## **Chapter 1. Introduction**

A criticism of public health research is that medical knowledge can only take us so far, and it is important that we also have an understanding of lay health motivators as well. Blaxter (1997) argues that individuals have access to multiple representations; concepts of health and illness are therefore not strict dichotomies as understandings of what health means varies. The importance of lay knowledge is therefore central as it gives an understanding of actual practice alongside an appreciation of theory. Popay and Williams (1996, p.760) maintain that public health research ‘must utilize and build on lay knowledge’ as it can bring an enhanced contribution to our understanding of health and illness. It is therefore essential that there is an ongoing dialogue between lay and professional experts, as lay health knowledge is different from, but arguably equal to that of professionals. Individuals’ perception of risk may differ to that proposed by health professionals; however peoples’ understanding of scientific knowledge can also influence their lay health beliefs. It is therefore important to gain an understanding of lay health, as it will give stronger resonance to the actual, rather than the idealised practice.

The importance of lay knowledge in health issues is well founded (Coveney, 2005, Henderson, 2010, Popay and Williams, 1996, Popay et al., 1998, Popay et al., 2003). Kemm (2006) contends that there are limitations to health based approaches as they ignore the complexity of the decision making process. This research will take a standpoint from women’s experiences (Stoller, 1993), with the aim to look at the reasons why women drink, how frequently they drink during pregnancy, what they drink and the relationship alcohol has within women’s lives in Scotland. An exploration of women’s perspectives and their understandings of policy and health recommendations is therefore vital when examining why people have differing attitudes towards health, especially towards an examination of women’s alcohol consumption during pregnancy. In this research I aim to understand alcohol and its use from a women’s perspective. Utilising a feminist approach will allow a deeper understanding of women’s health behaviour and their individual reasoning behind their lay health beliefs.

The consumption of alcohol is seen to be viewed as the norm in many countries around the world (Willsher, 2010). Alcohol is seen as part of the fabric of society

within the UK (Herring and Thom, 1997). However global concern exists over the levels of alcohol intake because of the negative social and health effects that the overconsumption of alcohol can encompass. The health implications of the heavy consumption alcohol are evident including a positive association between alcohol consumption and mortality (Morleo et al., 2011), its misuse contributes towards a wide range of health and social problems (O'Donnell, 2006). These include but are not limited to liver problems, high blood pressure, stroke, heart attack and increased risk of various cancers (NHS Health Choices, 2012).

### **1.1. THE CULTURAL CONTEXT OF ALCOHOL IN THE UK AND SCOTLAND AND THE INCREASING RATES OF ALCOHOL CONSUMPTION AMONGST WOMEN IN SCOTLAND**

Levels of alcohol consumption are high for the UK in comparison to other European countries as potentially damaging/hazardous drinking is a characteristic of the drinking pattern within the UK (Gill and O'May, 2011). Indeed Measham and Brain (2005) argue that the UK now has a culture of intoxication, where excessive alcohol consumption has become the dominant trend (Plant and Plant, 2006, Piacentini and Banister, 2009). In the UK binge drinking (consuming 8 or more units in a single session for men, 6 or more for women (NHS Choices, 2012)) occurs in 40% of all drinking occasions among men and women, a frequency which is substantially higher than in most other European countries (Heather, 2006). Rates of alcohol consumption continue to increase in the UK with over 10 million adults in England now drinking more than the recommended daily limit (National Audit Office, 2010). 34% of men and 28% of women drink more than recommended guidelines (Alcohol Concern, 2012). The UK Government introduced sensible drinking guidelines that state:

*Daily recommended guidelines are that men should not consistently drink more than 3 - 4 units of alcohol per day, and women should not consistently drink more than 2 - 3 units of alcohol per day.*

*Weekly guidelines are that men drink no more than 21 units and women no more than 14 units. It is also advised that people should have at least two alcohol free days during a week.*

(NHS National Services Scotland, 2010, p.16)

There have been a number of significant changes to the UK drinking culture, with the increasing trend in home drinking and high rates for off-sales of alcohol (Foster et al., 2010), this is considered to be a feature of cost, convenience and safety.

Scotland is of particular interest because of its long history of alcohol-related ill health. Renowned for its whisky, Scotland has strong ties with alcohol production with almost 6% of jobs having ties to the industry (Information Scotland, 2010). Yet it has what The Scottish Government (2012a) describe as an unbalanced relationship with alcohol. Alcohol related mortality within Scotland has more than doubled in the last 15 years (The Scottish Government, 2008b) to higher levels than the rest of the UK (The Scottish Government, 2010). Figures from the The Scottish Government (2008a) show that, from sales for the year 2007, Scots over the age of 16 drank, on average, the equivalent of almost 23 units of alcohol per week, compared to just over 19 units in England and Wales. Hazardous drinking also exists across all ages and social groups (Graham and Mackinnon, 2010). Despite a fall in the number of alcohol-related discharges from general acute hospitals in Scotland between 2008/09 and 2009/10 (NHS National Services Scotland, 2010) alcohol related harm remains Scotland's biggest public health challenge (Graham and Mackinnon, 2010) as The Scottish Government (2012b) estimates that the annual cost for the 'clear-up' of the misuse of alcohol is £3.6 billion each year in terms of the NHS, social work, police, emergency services, and the wider economic and human costs (Alcohol Focus Scotland, 2007). Johnston et al. (2012) calculated the overall cost of alcohol misuse in Scotland in 2009/10 to be £7457 million, with the burden of this being greatest in deprived groups. Evidence shows that those with lower socio-economic status drink in higher quantities (Casswell et al., 2003), yet the more affluent drinkers are more likely to drink at home (MacAskill et al., 2008). There are increasing levels of drinking at home (Pratten and Carlier, 2012), as off-sales increase and pubs are closing down (Eley, 2009).

Alcohol is therefore seen as a major public health issue for the country, which policy is seeking to address (The Scottish Government, 2009). Despite considerable publicity there is still failure in reducing the effects of overindulgence in alcohol. Indeed recent figures suggest, as evidenced by sales, that alcohol consumption is increasing (The Scottish Government, 2009) which is possibly influenced by the increasing affordability of alcohol (Graham and Mackinnon, 2010) seeing that

alcohol was 66% more affordable in 2009 than in 1987 (NHS National Services Scotland, 2010). The growing supply of cheap alcohol has led to a new set of public health concerns aimed at social change around the consumption of alcohol (Wimbush et al., 2007).

It is important that we understand the ways in which alcohol relates to the relationship between poverty and ill health. The rates of alcohol consumption in Scotland are very high and the high level of alcohol related ill health reflects this, having one of the fastest growing death rates for chronic liver disease and cirrhosis in the world (Information Scotland, 2008). Alcohol places a strain upon the NHS and also many other services across Scotland, and consequently there is an emphasis upon national and local action across Scotland to achieve long-term reductions in alcohol-related ill health.

With a national alcohol strategy since 2002 aimed to change the local drinking culture and attitudes towards alcohol in Scotland, a discussion paper entitled ‘Changing Scotland's relationship with alcohol: our strategic approach’ (The Scottish Government, 2008a) was published highlighting the policy changes to attempt to reduce alcohol related harm. These included legislative measures such as introducing minimum pricing, ending irresponsible promotions and a proposal to raise the minimum legal purchase age to 21 for off-sales. However, excessive drinking remains normalised in Scotland (Emslie et al., 2012); it is part of Scottish culture, and is therefore rendered normal and enjoyable (Van Wersch and Walker, 2009).

### **1.1.1. Women and Alcohol**

The gender gap between men and women's drinking in the UK has narrowed, and alcohol-related deaths among women have doubled in the last decade (Alcohol Focus Scotland, 2007). In recent years the noticeable trend for increasing alcohol consumption has been especially marked for women in Scotland. It was reported in 2012 that as many as 1 in 7 women in Scotland now drink to ‘hazardous’ levels (Information Scotland, 2010) and 1 in 4 women in Scotland exceed recommended daily limits (Alcohol Focus Scotland, 2007). Women are therefore putting themselves at a great risk for ill health and alcohol related illness.



It is evident that women's alcohol consumption in the UK has increased dramatically; there has also been an associated increase of drinking at 'harmful' levels. Scottish data estimate that 64% of women in general are drinking above the recommended daily limits, and that the number of women drinking at harmful levels has significantly increased, so that alcohol related-mortality among Scottish women is now higher than that of English men (McAuley, 2009). In 2009 'women's weekly consumption showed a similar pattern with the 16-24 age group reporting the highest mean weekly consumption level at 12.1 units per week, with consumption levels falling as age increases before rising again for the 45-54 age group' (NHS National Services Scotland, 2010, p.18). This increasing consumption has been accompanied by growing concern surrounding the increase in alcohol consumption amongst young women in the UK (Rúðólfsdóttir and Morgan, 2009). This issue has been readily identified by the media (Scotsman, 2008c, Barnes, 2012, BBC, 2009) and is a key issue that health policy wishes to address. However, Eriksen (1999) argues that the increased attention to the issue may have just made women's alcohol consumption more visible. The article by Kaye Fillmore (1987) 'When angels fall' also highlights the cultural preoccupation with women's drinking, revealing that the public and private split has broken down with a tendency to attempt to treat women's problems in a more public manner which would also explain the increasing attention paid to women's alcohol consumption.

## **1.2. OVERVIEW OF WOMEN, ALCOHOL AND PREGNANCY**

This increase in women's alcohol consumption has also initiated a marked increase in attention towards the role of alcohol in women's lives, leading to an amplified awareness of the role that alcohol plays during pregnancy. Plant (1984, p.157) argues that research from Scotland indicates that 'a sound basis now exists for advising those contemplating or experiencing pregnancy to stop drinking'. There is a growing argument that drinking during pregnancy represents a major public health problem, which is generating attention worldwide (O'Leary et al., 2007, Chen, 2012).

It appears that alcohol consumption during pregnancy in Scotland is common; however rates for women's alcohol consumption during pregnancy in Scotland differ greatly between studies. The findings of Plant (1984) from Scotland indicate that the majority (70.8%) of women reduced their alcohol consumption during pregnancy;

however 1.3% of the women in the study reported that their consumption of alcohol increased during pregnancy. It is concerning that within this research some women reported consuming a higher level of alcohol during pregnancy than their previous levels of consumption. From analysis of the Growing up in Scotland Survey (GUS) it is apparent that 1 in 4 women consume alcohol during pregnancy (Ford, 2008); contrastingly data for Scotland from the Infant Feeding Survey (NHS, 2007) suggest that 54% of women drink whilst pregnant. McAuley (2009, p.4) however contends that despite this, the levels of consumption appear to be low with 'only 8% of mothers reporting drinking more than two units per week on average'.

The risks of drinking alcohol during pregnancy and the negative impacts that heavy alcohol consumption can have upon the health of the unborn foetus have been well documented, especially within the United States. In the USA pregnant women who drink or take any psychotropic drugs have also become criminalised. The US Surgeon General has promoted abstinence from alcohol and alcohol containing medicines for pregnant women since 1981 (Barrison and Wright, 1984). In 2007, the UK Chief Medical Officer (CMO) addressed this issue and adopted a more preventative guideline. This precautionary approach recommends that all women who are pregnant or trying to conceive should abstain from alcohol completely during pregnancy. Additional advice also states that women should avoid consuming alcohol during the first trimester, due to the links with alcohol consumption and miscarriage (McAuley, 2009).

The National Institute for Health and Clinical Excellence (NICE) guidelines for the consumption of alcohol during pregnancy state that:

Pregnant women and women planning a pregnancy should be advised to avoid drinking alcohol in the first 3 months of pregnancy if possible because it may be associated with an increased risk of miscarriage.

If women choose to drink alcohol during pregnancy they should be advised to drink no more than 1 to 2 UK units once or twice a week (1 unit equals half a pint of ordinary strength lager or beer, or one shot [25 ml] of spirits. One small [125 ml] glass of wine is equal to 1.5 UK units). Although there is uncertainty regarding a safe level of alcohol

consumption in pregnancy, at this low level there is no evidence of harm to the unborn baby.

Women should be informed that getting drunk or binge drinking during pregnancy (defined as more than 5 standard drinks or 7.5 UK units on a single occasion) may be harmful to the unborn baby.

(NICE, 2008, p.62)

The Scottish Government recommends that women avoid drinking alcohol if they are pregnant, stating that women may prefer to take a cautious approach and avoid alcohol altogether. This is the approach also currently recommended by the UK Department of Health (NHS, 2011). This advice however extends beyond pregnant women and indicates that women planning a pregnancy should also be advised to avoid drinking alcohol in the first 3 months of pregnancy if possible because it may be associated with an increased risk of miscarriage (National Collaborating Centre for Women's and Children's Health, 2008). The new guidance also indicated that all women of childbearing age should be cautious. Some researchers feel that promoting abstinence during pregnancy is the safest choice (O'Leary, 2012, O'Leary et al., 2007); however considerable debate exists over whether abstinence during pregnancy should be advised (O'Leary and Bower, 2012) as such advice may generate excess fear and stress to mothers. It has also been argued that an amplification of the purported risks of drinking during pregnancy can also be a way of stigmatising and wanting to control women (Campbell and Ettorre, 2011) as, it is argued women are 'increasingly more scrutinised and subject to heightened social controls' in pregnancy (Upton and Han, 2003, p.688). Ettorre (1992) also argues that the biological effects of the consumption of alcohol during pregnancy are 'over-rated'.

The reasons why women drink during pregnancy have not been accurately examined, especially within Scotland since the introduction of the recommendation for abstinence. For example, evidence from the GUS survey suggests that drinking patterns in pregnancy differ by locality (Ford, 2008), with different drinking patterns for rural versus urban populations; however general drinking messages do not take these differences into account.

### **1.3. FOETAL ALCOHOL SYNDROME (FAS)**

Some evidence indicates that multiple negative outcomes are associated with heavy alcohol consumption during pregnancy such as miscarriage, stillbirth and central nervous system defects; however uncertainty still exists over the level of alcohol consumption that is harmful to foetal development. One severe effect of alcohol consumption during pregnancy is Foetal Alcohol Syndrome (FAS). FAS is a recognised medical condition; however there is great debate over the prevalence of it, as there are a range of symptoms of FAS, and not all children will exhibit all of these. In this sense the diagnosis remains very subjective to the physician, and is dependent upon willingness to diagnose the syndrome. Also some of the neuro-developmental symptoms associated with it are difficult to define until children are older. FAS is characterised by facial features, abnormal growth patterns and brain damage (for a more detailed description of FAS see Chapter 2). Both women's alcohol consumption and FAS have received considerable attention in the Scottish media, and The Scottish Government has contemplated undertaking a prevalence study of FAS (The Scottish Government, 2009).

Despite the change in guidance for women's alcohol consumption during pregnancy, there still remains a lot of confusion over the risks of alcohol consumption. Media reports have indicated that many women do not understand the risks associated with drinking during pregnancy (Mosley, 2013). This is therefore something that needs to be examined. To understand why women drink, it is important that we fully understand women's attitudes towards alcohol consumption, and also where women seek advice from, for example, midwives, relatives, peer group or the internet. It is particularly important to consider, therefore, the social context in which women drink and the lay knowledge that exists around the consumption of alcohol during pregnancy.

### **1.4. THE AIMS OF THIS RESEARCH PROJECT**

*1 An exploration of women's alcohol consumption during pregnancy in Scotland, primarily women's attitudes towards drinking during pregnancy and their awareness of the risks of consuming alcohol during pregnancy.*

In particular the research aims to further the understanding of attitudes to alcohol consumption during pregnancy as well as actual levels of consumption. It will be examined whether or not women are aware of the risks of consuming alcohol during pregnancy. It has been recognised that there is no ‘safe’ level of alcohol consumption during pregnancy; however, it is thought that low levels of consumption are not harmful. As the new Government Guidelines in Scotland state that women should avoid alcohol completely if pregnant or trying to conceive. Despite this it is evident that some women in Scotland still consume alcohol during pregnancy. This research will examine women’s attitudes to alcohol consumption during pregnancy, for example, do women’s patterns of consumption differ during pregnancy? Do women see drinking during pregnancy as something that is okay to do?

It is important, when examining women’s alcohol consumption during pregnancy to see if women are aware of current health campaigns or interventions, and evaluate their effectiveness. Women’s own understandings of the risks that alcohol consumption can pose and their understanding of health campaigns is important. For example, are some women unaware of the risks? There appears to be a wealth of information available on the subject of alcohol use during pregnancy, and therefore it is important to see if women are accessing these.

## *2 To further the understanding of the social and cultural context of women’s alcohol consumption during pregnancy.*

It is vital that we understand not only if women consume alcohol during pregnancy, but what influences their decisions to drink alcohol or abstain. By using a life course perspective it is hoped that our understandings of women’s alcohol consumption will be improved. Work has already examined the important social context of drinking (Szmigin et al., 2011). Situating women’s alcohol consumption in this way will help to see how drinking during pregnancy is related to prior drinking habits as well as those of peers and family. It will also examine to what extent the social and cultural context of women’s alcohol consumption is related to material conditions of young women’s lives and their own health and wellbeing. The current debate in Scotland on drinking cultures focussing on young women’s drinking has resonance for interventions for pregnant women. We need to recognise the cultural context of drinking, as well as the influence of peers and family. It is evident that

intergenerational experiences are often used as evidence of the lack of risk associated with drinking during pregnancy, and the role of this in women's alcohol consumption needs to be evaluated.

*3 To explore how women respond to health interventions and their attitudes towards existing public health campaigns and health interventions.*

It is evident that some women choose to continue to drink alcohol during pregnancy; the effectiveness of the existing interventions will therefore be drawn into question. There will be some analysis of the existing interventions and the research will also question whether 'at risk' groups are being actively targeted through the current interventions. It is evident from research into FAS that, there is no 'safe' level of alcohol consumption during pregnancy; however it is thought that FAS only occurs in children whose mothers are alcohol-dependent or consume alcohol to very high levels during pregnancy. It is important in the analysis of the existing interventions in Scotland, to determine if women who are 'heavy' drinkers are being actively targeted by these interventions. It is hoped that by viewing women's alcohol consumption in a life course perspective our understandings of women's alcohol consumption will be improved and interventions can be developed through this. It is thought that a comparison of exiting interventions with women's awareness of risks and experiences of alcohol consumption will be crucial in order to identify effective interventions.

## **1.5. THESIS OUTLINE**

Through addressing these objectives it is hoped that this research will draw attention to the complexities that exist around alcohol consumption during pregnancy and the importance of lay knowledge. This, I argue, is crucial if we are to gain a more detailed understanding of women's understandings the consumption of alcohol during pregnancy.

The remainder of the main body of this thesis is structured as follows. Chapter 2 provides an overview of the relevant literature available on women's alcohol consumption during pregnancy. It will firstly draw upon feminist issues and themes such as women and pregnancy and the ideology of motherhood. It will then in turn question drinking during pregnancy, examining the medicalisation of pregnancy

before finally examining the effects of consuming alcohol during pregnancy such as FAS. Chapter 3 explores the methodology behind this research project, exploring how the methodology utilised is feminist in nature discussing researcher reflexivity and the sensitive nature of discussing alcohol consumption during pregnancy whilst also examining the ethical issues of this project. Chapters 4, 5, 6 and 7 investigate the findings of this research. Chapter 8 provides a discussion of the findings of the project, highlighting again the original contribution this research makes and the complexities surrounding the issue of women's alcohol consumption during pregnancy. Finally the conclusions offer recommendations for policy and practice implications before giving an insight into possible further research that could follow as a result of the findings of this research project.

## **Chapter 2. Literature Review**

### **2.1. INTRODUCTION**

Drinking is recognised to be a rule-governed activity embedded with regulations defining who may drink, how much and what, they drink and in what contexts (The Social Issues Research Centre, 1998). It is widely regarded as a social activity, however subjects are expected to impose self-controls so that their consumption aligns with the normal social context (The Social Issues Research Centre, 1998, p.6). The work of Fillmore (1987) successfully highlights the cultural preoccupation with women's drinking. Alcohol has been a long standing feature within the UK, with its use traditionally linked with masculine norms of sociability. As Heath (1995) contends, alcohol is considered more suitable for men than women and alcohol problems are customarily associated with men (Plant, 1997).

But, the role women have played in the production of alcoholic beverages has been minimised, and as Plant (2008, p.156) argues women have played an important role in acting as 'informal social controllers of drinking and alcohol related behaviours'. Warner (2003) argues that the era of the 'Gin Craze' raised the alarm over both men's and women's heavy drinking. Indeed women's problematic drinking was portrayed in 'Gin Lane' by William Hogarth, a painting which depicts the citizens of 'Gin Lane' consuming vast quantities of gin, and a drunken mother about to drop her child. Muldoon (2005, p.159) argues that the painting is in fact 'a direct, public health promotional campaign to curb gin drinking and the complications of alcoholism' and the painting has led to other researchers such as Abel (2001b) questioning if Hogarth knew about FAS. Women's drinking was predominantly seen as socially unacceptable, due to the strong links between women and the home and the carer of the family. During the latter part of the 20th century women's use of alcohol rose considerably in the UK, yet Jayne et al. (2012a) argue that moral attitudes have not kept pace with this social change. The work of Thom (1997a) highlights the historical circumstances in which the concern over women's alcohol consumption became public. Eriksen (1999) however argues that the view that female alcohol consumption has been rising from a low and unproblematic level to an abnormally high level is false, instead arguing that as women's alcohol consumption has been high, just more attention is now given to it, as women were



traditionally more likely to consume alcohol within the private sphere. There is a general agreement that there is now a greater social acceptance of women's drinking (Plant and Plant, 2006, Thom, 1997b). To understand women's drinking it is therefore important that we understand the social construction of women's lives, positive/normative understandings, how alcohol is associated with motherhood, and how alcohol is rooted within social identities and norms (Livingstone et al., 2011). The lean towards a greater social acceptability of women drinking in Britain has coincided with a call for women to become more responsible in their drinking and to abstain from alcohol during pregnancy. The expansion of interest in women's alcohol consumption during pregnancy is, equated with the wider attention paid to women's alcohol consumption in Scotland. Yet women are still viewed as having a complicated relationship with alcohol.

Scotland has a successful history of alcohol production and export, especially in the trade of whisky (Thomson, 1980, Spracklen, 2011), which is seen as having an emblematic nature for Scottish identity (Holden and Hawkins, 2012). Alcohol, especially whisky, is generally regarded as a familiar part of stereotypical Scottish identity as Cochrane (2011, p.310) observes 'images of tartanry along with discourse of alcohol abuse are at times knitted together, providing decidedly negative symbolisms of Scottishness'. This exemplifies how alcohol-related problems are associated with specific cultural factors, relating to expectancies and normal attitudes towards drinking (The Social Issues Research Centre, 1998). Indeed, within the media, the cultural identity of alcohol issues and the origins of Scottish excess is portrayed by columnist Riddoch (2010), who argues that: 'It's not that Scots tend to drink. It's that you have to drink to be Scottish'. This is not surprising given that the consumption of alcohol in the UK has more than doubled since 1950, a noticeable increase occurring since the early 1990s (The Scottish Government, 2008a); this has coupled with an increase in alcohol-related morbidity and mortality (McKenzie and Haw, 2006). The Scottish relationship with alcohol is depicted as an encompassing national problem, and a major health issue. Alcohol is consequently a key issue that the Scottish Government seek policy to address (Holden et al., 2012). The diversification of the product base and aggressive advertising and marketing is something which is also specifically targeted by the government (McKenzie and Haw, 2006).

In the UK in 2007, the Chief Medical Officers (CMOs) adopted a precautionary approach to alcohol consumption during pregnancy and advised women who are pregnant or trying to conceive to avoid alcohol entirely. NHS Choices publications inform women that ‘there is no question that alcohol passes freely across the placenta to the foetus, and that heavy drinking can damage foetal development and lead to a condition called foetal alcohol syndrome’ (NHS, 2011, p.15). Whilst noting that it is complicated to calculate the effects of drinking during pregnancy, the publication recognises that other lifestyle and socio-economic factors can be of influence but that ‘so far the research has found no conclusive evidence of harm from small amounts of alcohol in pregnancy’ (NHS, 2011, p.16). The Scottish Government framework states:

We have already taken action in relation to pregnancy. Scotland’s Chief Medical Officer, jointly with the other UK Chief Medical Officers (CMOs), has issued clear advice that women who are pregnant or trying to conceive should avoid alcohol. We strongly support the voluntary agreement with the alcohol industry which encourages the inclusion of the CMOs’ pregnancy advice on all alcohol products and would support action to make such labelling mandatory. At the extreme, alcohol use during pregnancy can result in babies being born with Fetal Alcohol Syndrome (FAS), characterised by restricted growth, facial abnormalities and learning and behavioural disorders. The number of cases of FAS diagnosed each year is low, but it is thought that a greater number go undiagnosed. We will arrange a Scottish survey of the incidence of FAS

(The Scottish Government, 2008a, p.22)

The recommendation is now for abstinence; however this perspective fails to address the lack of certainty regarding harm from the consumption of alcohol during pregnancy, or the way in which alcohol is embedded within Scottish culture.

The rest of this chapter is structured as follows. The first part examines theories on women and the discourses of motherhood (Lawler, 2000, Rich, 1997, Rothman, 2000, Miller, 2005), from a feminist perspective looking at the ‘good’ mother ideology (Miller, 2005, Phoenix et al., 1991, Lupton and Fenwick, 2001, May, 2008). Discourses such as the medicalisation of motherhood, with an understanding

of issues of power and surveillance are examined. It then draws upon the work of Ettorre (1992) and Oakley (1984) to examine theories around women and pregnancy, focussing upon associations between the discussion of pregnant women who use drugs and alcohol and scrutinising the idea that the pregnant woman is vulnerable. Secondly, the role of drinking during pregnancy will be highlighted with an awareness of the issues of surveillance and power as developed by Foucault (1979) and the dominance of women bodies by men. Finally, figures outlining the problem of drinking during pregnancy in Scotland will be discussed, with an examination of the effects of drinking during pregnancy, concentrating on Foetal Alcohol Syndrome (FAS) and the conflicting discourses that surround women's alcohol consumption during pregnancy which position FAS as the latest moral panic.

## **2.2. MOTHERHOOD**

### **2.2.1. The discourses around motherhood**

The work of Rothman (2000) reveals how there are varying definitions of motherhood, for example as a 'master status' whereby everything is seen in terms of motherhood, or as a service or work. Motherhood is seen as an ideology that affects all women and Phoenix et al. (1991) argue that being a woman is generally equated with being a mother. Miller (2005, p.3) defines mothering as 'the personal, individual experiences that women have in meeting the needs of and being responsible for their dependent children', and uses the term 'motherhood' on the other hand to refer to 'the context in which mothering takes place and is experienced' (Miller, 2005, p.3). Motherhood is therefore seen in reduced terms as it is condensed to the specific act of mothering, eliminating the power that women have. It is therefore one of the major institutions which oppresses women and prevents them from taking more active control over their own lives (Lois, 2010, Rich, 1997). In her study of women and housework Oakley (1974) discusses the taken-for-granted assumptions that are made of women, in regards to domestic labour and the naturalising association of women with femininity and the home.

It is argued that motherhood forms an essential part of all women's identity, and a crucial and central aspect of women's development. As Phoenix et al. (1991) argue, motherhood is an essential stage of women's development and a crucial part of their identity from as early as childhood. Women are therefore viewed as potential

mothers from a young age and 'continue to be defined in terms of their biological functions' (Phoenix et al., 1991, p.7). Motherhood is, therefore, central to the ways in which women are defined, some definitions even view motherhood as 'women's 'natural' biological destiny' (Phoenix et al., 1991, p.66, Ettorre, 1994, Ehrenreich and English, 1974). As Longhurst (2000b) argues, medical discourse represents women's bodies as bodies that are waiting for babies. Kirkman (2008) highlights how many women grow up with a pre-existing sense of motherhood, knowing that they will want children in the future, and therefore, having expectations of motherhood. In this sense, women are defined by their ability to mother regardless of whether they have children or not. Miller (2005) argues that the patriarchal assumptions that all women desire to become a mother is a defining feature of womanhood. This romanticised category defines motherhood as 'the supreme physical and emotional achievement in women's lives' (Phoenix et al., 1991, p.13). There is therefore pressure upon women in western countries to fulfil their biological destiny and become mothers. It is also expected that all women's experiences of motherhood should be positive. Because of the cultural expectations that see women as mothers, women are historically blamed for childlessness: their failure to reproduce is seen as moral failure and a failure of gender (Kirkman, 2008). Consequently Kirkman (2008) suggested women who have not conceived often feel stigmatised and fear that others view them as pitiable, desperate and less than whole. The process of being stigmatised occurs when the dominant group perceive other individuals to be threatening or undermining the values of the dominant society by their difference (Whitehead et al., 2001).

Valentine (2001) argues that our identity is important to women's notions of the self and is influenced by how we choose to convey ourselves, which also takes into account the ways in which other people identify us. Arguably, identity is not fixed as it is liable to change. For example, Miller (2005) has argued that life events, such as becoming a mother, provide opportunities to explore the ways in which selves are constituted and maintained. This argument sees the self as socially constructed, a continuing project to be worked on. Women are therefore able to manage the self so as to present different selves in different settings (Lawler, 2000). Miller (2005) argues that pregnancy and motherhood are a fluid time, where women will experience great change and our identity is challenged by the experiences of

becoming a mother. Miller (2005) also considered that our identity, is challenged by the experiences of first time motherhood as a new social self as mother has to be learned. Thus there is a notion that women give up their former identity and sense of self during pregnancy. This is evident in the research into the transition to motherhood, where many women indicate that they felt a need to 'get back to normal' and a 'return to the self' after having a child (Miller, 2005, p.14). As one mother expresses in Carrie and Yosepha (2002, p.422) 'I just don't feel like me anymore'. Motherhood is therefore a highly fluid time for women as the transition to motherhood involves a shifting sense of self (Miller, 2005) which clearly has an impact upon how motherhood is experienced. Lois (2010) argues that there exists a temporal suspension of self and that this change of self is linked to sacrifice and not just progression.

The experience of becoming a mother is shown to have diverse affects upon the identity of women as women are defined in the terms of their ability to mother. Because motherhood is socially constructed, there are various ways in which motherhood can be socially devalued. Part of a women's identity is that of a producer, as Rothman (2000, p.6) suggests that pregnant women are perceived to be 'unskilled workers on a reproductive assembly line', I would argue that this image also constructs an illusion of women as helpless. As previously argued, a woman's identity is shaped through the potential to produce children and in this respect women's identity is defined through motherhood. Motherhood is a proof of adulthood, a privilege and a duty but identity formation rests upon social comparison with others (Letherby, 1999). Women can consequently be viewed, in certain circumstances as little more than a resource. The tasks of motherhood, such as pregnancy and breastfeeding, or quitting economic work can be difficult for women, yet motherhood is construed as work; with children as a product produced by the labour of mothering (Rothman, 2000). Women who have paid employment therefore encompass a double identity as a caregiver and an economic subject (Ruddick, 2007a).

The idea of motherhood as a natural destiny reveals dominant conceptions about how mothers are supposed to appear. As previously demonstrated, generally within western society it is presumed that women want and desire to become mothers (Shelton and Johnson, 2006). However, concomitantly there is the increasing

phenomenon of women postponing childhood, e.g., to pursue a career, or to feel psychologically or economically prepared. Delayed motherhood has therefore been associated with a number of advantages to women. However, Shelton and Johnson (2006) believe that for women this can be ‘double-edged’. Although motherhood at older ages is now socially acceptable as it bestows certain psychological advantages, the ideologies of motherhood impose expectations which can force women into particular ‘ways of being’ which undermine their sense of identity (Shelton and Johnson, 2006, p.328).

Motherhood is a morally shaped concept, with the notions of ‘good’ and ‘bad’ mother entwined with the ideas of right and wrong (Miller, 2005). Certain dominant discourses affect the ways in which ‘good’ and ‘bad’ mothers are socially constructed (Phoenix et al., 1991). Lawler (2000) contends that mothers are perceived to be the guarantors of good society; consequently women are therefore defined in terms of their mothering. The extent that a woman is perceived as a ‘good’ or a ‘bad’ mother is based upon the woman’s ability to mother, including the extent to which they meet a child’s physical and emotional needs.

Developing this argument, Davies and Allen (2007) concede that women may produce accounts of their behaviour in line with what they believe to constitute ‘good’ mothering. The professionalization of motherhood as described by Phoenix et al. (1991) has therefore served to pressure women into performing the role of the ‘good’ mother. Although the body is an object of power that is controlled (Ettorre, 2008), Ettorre (2007) contends that the female body emerges as a site for acts of resistance as well as conformity. In the book “Gendering Addiction” Campbell and Ettorre (2011) highlight various arguments around women and addiction and the key concept that the attitudes towards women and addiction appear to be re-invented continually through the epistemology of ignorance mainly through the exercise of patriarchal power by men (Ettorre, 2007). The role of the ‘good’ or ‘bad’ mother and the discourse of femininity has changed alongside women’s changing roles in society, which also has connections with the historical discourse of alcohol.

### ***‘Good’ mother***

As already discussed, motherhood is accorded great significance (Miller, 2005). Mothering is a gendered activity and the ‘good’ mother is associated with feminine

characteristics, as the category mother is constructed under the terms of patriarchy. For example:

The 'good' mother is perceived in a positive light, with 'good' mothers including qualities of 'patience, unconditional love and kindness concerning how women relate to their children. 'Good' mothers are expected to 'be there' for their children and to develop a 'strong' bond with them. They should place the needs of their child above their own

Lupton and Fenwick (2001, p.1011)

'Good' mothers are expected to fulfil the societal expectations of them and seek out and follow appropriate advice (Copelton, 2007), however the perceptions for a 'good' mother change over time. Being a 'good' mother is a successful presentation of self (May, 2008) and infers behaving in a morally acceptable way. These social norms around motherhood also regulate good behaviour, for example alcohol consumption (May, 2008). How women are viewed can change within different settings, for example Lupton and Fenwick (2001) examine how mothers construct and relate to the notions of 'good' motherhood' within the setting of a special care nursery. Within this predominantly public setting, mothering is constantly supervised and regulated by nurses within the nursery whose discourses produced their own standards of a 'good' mother. There are strong expectations of how mothers should act/feel/do and women have their motherhood categorised as 'good' or 'bad' depending on how their behaviour aligns with the strict moral codes around motherhood (Lupton, 2013, Beynon-Jones, 2013).

Phoenix et al. (1991) found that childcare and parenting manuals constructed mothering to be unproblematic; negative experiences such as the blues were defined as irrational women's troubles. Therefore, mothers who experience the 'blues' are perceived to be 'unnatural', having 'faulty' bodies. It has been recognised that the dominant ideology of motherhood is that it is in general a pleasurable and fulfilling experience, and therefore women who experience negative feelings towards it are unnatural. Expectations made of women align 'good' mothering with the quality of being responsible. Issues also arise here where a mother's behaviour conflicts with the medical advice set for pregnancy. Women who drink alcohol during pregnancy

and go against the recommendation for abstinence are therefore, stigmatised and classed as ‘bad’.

### ***‘Bad’ mother***

Vincent et al. (2010) argue that the dominant ideology of intensive mothering has become normalised. This intensive mothering has a class orientation, as the ‘bad’ mother is linked to perceptions of immoral behaviour, and often of being lower class. ‘Good’ motherhood is a socially constructed phenomena which is liable to change throughout time, and is generally shaped by white middle class gender norms (Hays, 1996, Springer, 2010). Generally lower class women are excluded from the definitions of ‘good’ mother; instead critics argue that it is ‘a political tool used to scapegoat ‘bad’ mothers for societal problems’ (Springer, 2010, p.482). Indeed poor mothers have often been particularly stigmatised (Dodson, 2007, Williams, 1994, Collins, 2000, Caplan, 1998, Dodson, 2013), for example Mac an Ghail and Haywood (2007) examine the role of maternal deprivation and latchkey kids.

The value given to ‘normative’ mothering (Vincent et al., 2010) ensures that women therefore compare their mothering to that of others and the unrealistic standards which have been generated by the media (Douglas et al., 1993, Bullock et al., 2001). Media coverage is consequently used as a rhetorical tool to define the ‘bad’ mother (Springer, 2010) with the threat of punitive action if they fail in being defined as ‘good’. Gendered differences exist in the definition of parenthood between the mother and father as the moral imperatives applied to women’s parenting are not applied to men (Lynch, 2007) and as Pedersen (2012) comments, motherhood includes the act of ‘gate keeping’ efforts to control participation by fathers.

There are strong ideological positions of how women are valued or devalued as good/bad mothers, for example single mothers (Skeggs, 2004). There is a long history of state-generated discourses of ‘bad’ mothers and the single mother has become a source of national evil (Skeggs, 2005). Political debate in the 1990s characterised single mothers as a serious social problem (McCormack, 2005) and a threat to the family. Within this population, single mothers by choice (Bock, 2000) are particularly stigmatised thus revealing the on-going importance of marital status for the experience of mothering (Christopher, 2012). Teenage mothers have also been constructed as deviant (Wilson and Huntington, 2006, Fraser and Gordon,



1994, Luker, 1996). Other groups of women are also marked as outside of the discursive construction of good mothers (McCormack, 2005). These include but are not limited to substance abusing mothers (Baker and Carson, 1999) or mothers suffering from addiction (Kilty and Dej, 2012); lesbian mothers (Dunne, 2000); mothers suffering from postpartum depression (Held and Rutherford, 2012); or mothers liable to be judged for working instead of being a full-time mother (Hays, 1996).

However by positioning themselves as ‘good’ mothers, women often reinforce the system. As McCormack (2005, p.676) infers ‘by relying so heavily on fulfilling traditional notions of motherhood, these mothers help to perpetuate a definition of motherhood that relies in part on traditional gender roles and the availability of adequate resources’. Media coverage also reflects and perpetuates anxiety about mothering, especially mothering by lower class women. Springer (2010, p.476) develops this argument further and suggests that the framing of news stories has little to do with protecting the health of children rather; ‘concern for children is a rhetorical tool used to define poor and minority women as bad mothers and blame them for contemporary changes in families’. The notion of the ‘good’ or ‘bad’ mother is therefore a discursive strategy used to label some groups of women as unfit mothers, linked with the idea of moral failure

There is a wealth of literature around the topic of motherhood and other examples of what is a ‘bad’ mother include but are not limited to: substance-using women (Reid et al., 2008), drug-using women who are poor and minority women as bad mothers (Springer, 2010), the popular characterization that young mothers are bad mothers (Hunt et al., 2005), the stigma of being a bad mother and mothers when children have invisible disabilities (Francis, 2012). These and other women are punished for not conforming to the ideologies of good mothering.

The notion of a ‘bad’ mother infers a lack of care for children and hints at being irresponsible. Women who choose to drink, therefore placing their unborn child’s health at risk are conflicting with the ideology of the ‘good’ mother’ and are consequently vilified within the media for their behaviour. It is evident from looking at recent media articles (Barnes, 2012, Bennett, 2007, Scotsman, 2006, 2007a) that the increased media awareness of FAS, has led to increased control over women’s

bodies. Consequently women who consume alcohol are identified as 'bad' mothers in that as Ettorre (1997) contends, in the case of alcohol, the stigma of a 'bad' mother may even prevent some women who do have alcohol problems from receiving treatment. Women may fear of being labelled an 'alcoholic' or having their mothering judged, or fear that admitting to having problems with alcohol may lead to losing their children (Murphy and Rosenbaum, 1994).

### ***'Other' mother***

Mothering is not a universal experience and is full of complexities and ambivalences; conflicting meanings of motherhood therefore exist. Phoenix et al. (1991) argue that some groups of mothers are valued over others. The category of 'other' is used to represent mothers whose mothering is viewed as deviating from notions of 'good/normal' mothering (Phoenix et al., 1991). Davies and Allen (2007) examine the ways in which mothers with mental illnesses are constructed as the 'other' because, 'in Western societies, mental illness is not a part of the 'ideal' of motherhood' (Davies and Allen, 2007, p.369). The experience of being 'other' has also been examined in relation to the experience of non-mothers (Woollett, 1991), the involuntary childlessness (Letherby, 1999, Letherby, 2002) and infertile women (Kirkman, 2008). Women in this position may only be able to experience 'motherhood' through 'other' forms of mothering for example, adoption or IVF (Pfeffer, 1987). For these women their mothering is different, and is therefore constructed as 'other', and the women's perceptions of their mothering recognised how they felt different.

From analysing these non-traditional family structures, Letherby (1999) comments that it is evident that there is a higher social value of biological motherhood than social motherhood, and there are strong associations of motherhood and the 'family'. This diversity of experience contradicts the 'assumptions that mothering is dependent on 'instincts' and being 'natural'' (Miller, 2005, p.86). Yet these differing ways present examples of how women construct and negotiate motherhood. For women who do achieve motherhood through a 'non-natural' way, there is the risk that they can be seen as an 'other', as they have not achieved their motherhood in the 'normal' way and they fall outside the normative discourse of genetic connection between mothers and their children (Kirkman, 2008). As Kirkman (2008) explains, it

is not surprising that some women had difficulty in developing a 'normal' motherhood where there is such professional emphasis on abnormality. Undoubtedly, the acts of motherhood and parenting can impede this sense of not being a 'real' mother.

### **2.2.2. Class**

I have examined the concept of class through the work of Bourdieu (1987) as built on and critiqued by other writers such as: Skeggs (2002) and Skeggs and Loveday (2012). Bourdieu (1989), in his definition of metaphors of capital (economic, symbolic, social and cultural), examines how people accrue capital, or the 'habitus'. The model allows for an understanding of how bodies have access to different amount of capital, where the middle class protects its interests through symbolic boundary making thereby distinguishing itself from other classes. The critique of Bourdieu by Skeggs and Loveday (2012) asserts that this does not include the effect that institutions, education and other mechanisms of distinction prevent some individuals from legitimising themselves as 'subjects of value', therefore there are 'new conditions of legitimation'...by which individuals are 'required to repeatedly reveal its value through its accrual and investment in economic, social and cultural capitals' (Skeggs and Loveday, 2012, p.472).

Drawing on the work of Bourdieu (1987), Skeggs and Loveday (2012, p.472) assert that class relations are therefore lived through a struggle 'against unjustifiable judgement and authority for dignified rationality', and that moral evaluations form a distinction between classes, with the working-class blamed and held accountable, as well as constantly judged, for their behaviour. The work of Skeggs (2009, p.629) is therefore highly relevant to this research in its examination of class and how 'certain bodies become inscribed with certain characteristics', for example the ways in which types of behaviour are expected from certain types of people. I would argue that drinking during pregnancy is an example of this. As Skeggs and Loveday (2012, p.473) argue, there are 'historical legacies of distinction, which symbolically mark particular groups as bearers of bad culture, faulty psychology, and potentially degenerate and undeserving'. Through this system of exchange, value is inscribed on the body, for example the body who drinks to excess and who drinks during pregnancy, becomes institutionalised and distinguished as 'bad'. Value claims of the

middle classes who want to attach value to the normative consensus portray the working class as having excessive femininities and antisocial behaviour.

Our public performance reveals how individuals make a stake for value or legitimacy (Skeggs, 2004) and this discussion of self-performance is developed by Skeggs (2009, p.628) through an examination into reality television, where ‘transformation is often structured through class relations whereby one group’s standards are found lacking and in need of improvement’.

### ***How class contributes to concepts such as motherhood***

As reflected through analysis of the growing up in Scotland data set (Ford, 2008), class is an important variable in women's alcohol consumption during pregnancy. This analysis revealed that within the higher classes more women reported alcohol consumption in pregnancy. For example, of the group who had never worked, only 15% reported that they consumed alcohol in pregnancy, compared to the one in four women within the intermediate occupation, 35% of the managerial and professional class and 10% of the women in semi-routine and routine occupations (Ford, 2008). However, the observed differences between alcohol consumption and class could have been influenced by differences in the reporting of alcohol consumption of women. Middle class women may perhaps be more likely to report alcohol consumption more accurately.

Those who appear feminine are granted the power to evaluate others (Skeggs, 2001) as a ‘deserved authority’ (Skeggs and Loveday, 2012). We know our positioning in our comparisons to others by their visual value which is evident through the body. As Skeggs (2001) argues, femininity is judged on the basis of excess, and is given the authority to shame and judge. There is thus a class underpinning of how bodies are read on the basis of appearance. For example, the welfare mother is stigmatised for creating a reproductive underclass (Jencks, 1992). The welfare mother is therefore ‘a powerful symbol of the supposed irresponsible, sexually promiscuous, and immoral behaviour of the poor’ (McCormack, 2005, p.660). These dominant ideologies of class thus reveal the welfare mother as not just a poor mother but a ‘bad’ mother (McCormack, 2005). Because of the historical and social context of motherhood and the powerful ideologies that blame the poor for their own poverty, lower-class women often experience and interpret motherhood differently than class-

privileged mothers (Christopher, 2012). Criticism also exists of non-traditional family forms as uncontrolled (Christopher, 2012) as McCormack (2005, p.661) purports: 'motherhood continues to be venerated when the mothers are middle and upper class, married and white; the mothering done by poor, non-white women, however is systematically devalued'.

There is a shame associated within working class struggles, however as Skeggs and Loveday (2012) argue that struggle as a performance is valorised within working-class culture. There is therefore a significance of loyalty and honour within the working class as Skeggs and Loveday (2012) argue working-class mothers defend their value by investing in caring as a source of value. Motherhood is therefore an accrual of value and this is important for our discussion of the 'good' mother and for the implications of the consumption of alcohol during pregnancy.

Some health behaviours, for example smoking, are more concentrated in socially disadvantaged groups and these class differentials are also becoming increasingly gendered (Holdsworth and Robinson, 2013). Some health behaviours are becoming increasingly bound up within class identities. This means that 'behaviours that are specifically ascribed as 'working class' are increasingly associated with individual failure and moral weakness' (Holdsworth and Robinson, 2013, p.106).

### **2.2.3. Motherhood and public health: how the body is changed through pregnancy**

There are some desired behaviour changes in pregnancy which 'good' mothers should be seen to prepare for such as smoking highlighted through a number of studies (Graham, 1976, Lawrence and Haslam, 2007, Shoff and Yang, 2013) and for example the work of Wood et al. (2008) highlights the cultural contexts and barriers to smoking during pregnancy amongst indigenous women in Australia. Even what type of food women eat can be scrutinized, as Mansfield (2012) argues the regulation of seafood consumption focuses on childbearing women. There is also the idea that women should reduce alcohol consumption (McBride et al., 2012).

Parr (2002) envisages the body as an important space of meaning and it is recognised that becoming a mother is a highly embodied experience. Longhurst (1999, 2000a) argues that part of women's transition to motherhood is the way the body is changed

through pregnancy and Rothman (2000) argues that women experience pregnancy with their whole bodies, ranging from changes in hair to weight gain. A 'good' mother is expected to follow a healthy diet as healthy eating in pregnancy is linked with the 'good' mother ideal. Pregnant women have to be careful of the food they consume as some are labelled 'bad'. Copelton (2007) contends that the consumption of some foods can be seen as a risk or a weakness symbolising a failure to accept the responsibilities of motherhood. What pregnant women therefore consume is highly regulated. Being pregnant can improve a woman's diet as she recognises the effect that her diet has on the growing foetus; however Micali et al. (2007) recognised for women with eating disorders that pregnancy can create a problem as the bodily changes such as weight gain can lead to a relapse. Other conditions such as obesity in pregnancy can also threaten the health of the mother and unborn baby with elevated risks including stillbirth, and problems associated with pre-eclampsia and obesity (Brockelsby and Dresner, 2006). Brockelsby and Dresner (2006) reveal how obesity during pregnancy is also strongly linked to an increased risk of postnatal depression and reduced breast-feeding rates and also carries problems for labour, with surgery being more common. Other problems such as excess weight gain (Brown et al., 2012, Warren et al., 2012) are also highlighted.

This portrays the idea that what is going on within your body does not just belong to you but that other people in groups or communities have a right to invade to protect the body,. Now it is not only what is going on inside the pregnant body that is being measured but the pregnant body is viewed as a public body, that people can touch (Longhurst, 1999, 2000a). Despite this during pregnancy there is a lot of control over pregnant women, casting them as vulnerable.

### ***Are pregnant women really a vulnerable group?***

Linked to the patriarchy over women's bodies is the ways in which pregnant women are often designated a 'vulnerable group'. The cultural representation of the pregnant women is one of vulnerability, in need of protection and treatment. Pregnant women are highly scrutinised and are told to follow specific diets and exercise patterns to benefit the health of their unborn children. I would argue if women truly vulnerable whilst pregnant? Or if by labelling women and treating them as vulnerable do we

make them vulnerable? If this is the case are women being uncritically labelled as being vulnerable when they are pregnant, when in fact pregnancy is a normal healthy state?

By drawing on the work of Oakley (1984) we can examine how the medicalisation of pregnancy has led to the monitoring and surveillance of women through both birth and pregnancy. Oakley (1984) argues that antenatal care is something which is 'done' to women representing as a strategy for the social control of women and their bodies. The vulnerability of women under the control of men is therefore highlighted. Lupton (1999b, p.63) argues that 'It would become difficult for a pregnant woman not to become drawn into the discourses of risk that surround her. Most medical and many lay discourses tend to represent the pregnant body itself as inevitable deviating from the norm, as vulnerable and susceptible to a range of ills and risks'. These discourses maintain that the pregnant body is vulnerable, which is connected to the way in which health professionals often treat pregnancy as a period of illness (Longhurst, 2000b, Young, 1990), during which women are unable to make choices regarding their own bodies. Women in this sense are shaped as vulnerable and made to be susceptible. They are reduced to unhealthy bodies in need of medical treatment, and face a lack of agency in the decision making process. Another way that this is also evident is through the education of mothers which assumes maternal ignorance and that women do not know what is best for them or their unborn child when they are pregnant, thereby treating women as containers for a foetus. Women in this respect lose control over their own bodies as the foetus assumes more rights than the mother. Cases where women have been prosecuted for child abuse for consuming alcohol or drugs whilst pregnant are examples of this (Daniels, 1993) (see section 2.11.1 for further details of this)

### **2.3. PUBLIC HEALTH AND LAY HEALTH**

Petersen (2003) emphasises how health promotion enables people to increase their control over their health and therefore improve it. Areas that are individually modifiable are particularly key areas for health promotion (Tannahill, 1985).

Popay et al. (2003) discuss how lay perspectives on health and illness were traditionally conceptualised as detached from formal scientific practice, yet both lay and professional knowledge both have a contribution to make to understanding

(Popay and Williams, 1996). It is evident that when it comes to health-related behaviours, different knowledge exists between professional experts and lay people, and traditionally these perspectives have been thought of as separate (Popay et al., 2003). With more credibility and importance usually given to medical opinion, health practitioners have long recognized that lay people have opinions about the causes of ill health which they or others experience. These opinions are constructed as interesting, but in some ways misguided (Popay and Williams, 1996) and therefore there has been a reluctance to utilise lay knowledge. Although medical knowledge is still granted a superior status, there has been an increasing awareness that more credence needs to be given to the importance of lay knowledge (Blaxter, 1997, Davidson et al., 2008, Watkins et al., 2002). Giving an increasing awareness to the notion that the manner in which people understand the nature of scientific knowledge is influential in setting health recommendations.

Tannahill (1985) argues that more dialogue is needed between the general public and professional experts as public participation and empowerment will make choosing health behaviours an easier process. Greenhalgh and Wessely (2004) argue that the lay expert has become important, and this is evidenced by Henderson (2010) who argues that lay knowledge can contribute to a better understanding of the issue people face. Informal stories and lay beliefs are important in shared pregnancy narratives (Lowe et al., 2009). In her study on smoking, Graham (1976) found that pregnant women were more responsive to health information from lay sources such as family or friends, with a preference to personal proof in opposition to standardised health information. The work of Graham (1976) highlights the importance of who messages come from in women's behavioural choices during pregnancy. The contribution of an understanding of lay knowledge can extend our understanding of health and illness and will increase the understanding of the relationship between social circumstances and individual behaviour. Following this idea is that lay knowledge will assist in making recommendations for public health policy, the significance of which needs to be more widely acknowledged. For example the work of Graham (1987) on smoking highlights how women who use cigarettes to cope with the stress of daily life do not lack knowledge about the negative health consequences of smoking. Respondents in a study by Watkins et al. (2002) tended to gain health information from *ad hoc* sources, revealing the importance of lay



knowledge. Yet Lowe et al. (2009) discusses that the internet poses a challenge to medical hierarchy.

There has been an increase in attention to the role of the individual in managing health. Pill and C (1985) and Caan (2012) discuss that, within the UK, most public health approaches to alcohol focus on the behaviour of individuals. This has also taken place alongside a shift from curative to preventative medicine (Pill and C, 1985). Crawford (1986) argues that this increase in individual responsibility for health has become emphasised as a way of passing the blame for illness to the individual. There is a growing idea intertwined with notions of responsibility that individuals should do the right thing in regards to their health. However the responses people have 'are complex, sometimes counterintuitive and also sometimes have unintended outcomes' (Thompson and Kumar, 2011, p.106).

As individuals are increasingly being asked to take responsibility for the management of their own health (Bunton and Crawshaw, 2006) there has been increasing concern within public health towards dangerous individuals, with the aim to regulate potentially risky behaviours (Bunton and Crawshaw, 2006). Evans (2006) argues that we need to pay close attention to the understandings of what constitutes morally appropriate behaviour as we call individuals to take individual responsibility for their health. The empowerment of individuals is therefore important for creating individual responsibility. We need to recognise that people negotiate health promotion strategies in complex and contradictory ways (Thompson and Kumar, 2011), and that people deal with health promotion strategies through resistance, denial and othering. When letting people take individual responsibility for their consumption of alcohol during pregnancy, we must realise that individuals' perception of risk may differ to that proposed by the recommendation for abstinence.

The influence of lay health beliefs is especially important given the importance of women as lay knowledge guardians. Coles et al. (2010) suggests that managing health has been traditionally seen as a feminine responsibility, yet in their research found that alcohol interventions involving the family are effective, arguing that we need to understand the importance of family ties, history and quality of relationships. Yet drinking guidelines are aimed at the whole population (Stockwell and Room, 2012). Advice on drinking during pregnancy therefore fluctuates between

precautionary and presumed risk, as Stockwell and Room (2012) examine there are ethical considerations in communicating risk to the whole population. There has been a proliferation of expert knowledge on pregnancy (Lupton, 1999b) and women in the UK are now encouraged to educate themselves through formal advice on the topic of pregnancy (Lowe et al., 2009). Billingham (2011) argues that the uptake of antenatal education is variable, but that expectant parents are intrinsically motivated to do what is best for their child.

## **2.4. WOMEN AND ALCOHOL (ALCOHOL AND GENDER)**

### **2.4.1. Feminist interpretations of women and alcohol**

Drawing upon the work of Ettorre (1992), Oakley (1993), Rothman (2000) and Waterson (2000b), this research seeks to understand women's alcohol consumption from a feminist perspective. Feminist research examines the politics of knowledge production, questioning what authority, if any, is invested in knowledge (Longhurst, 2001). Traditionally different sets of judgements have been used to define men's and women's alcohol consumption, with approaches to studies on alcohol coming from a masculine standpoint, consequently, marginalising women's experiences. Ettorre (1997) examines how women's alcohol consumption is viewed as a social problem that needs to be controlled and that male drinking has been sanctioned yet women's drinking is perceived to be unfeminine and deviant. This existing gender differentiation portrays alcohol problems as a 'social fact' of masculine excess with drinking has often been viewed as a normal demonstration of masculinity (Rúðólfssdóttir and Morgan, 2009). Additionally, women who drink heavily are judged more harshly than heavy drinking men and in general women who drink are argued to be more destructive than men, even blamed for the alcoholic excesses of their husbands (Ettorre, 1997). This masculinise standpoint exerts a double standard between the ways in which women and men are viewed by society as there is greater acceptance of the intoxicated man. Continuing this theme, Ettorre (1997, p.87) argues that this is in part due to the way in which 'women's behaviour is more bounded by social sanctions and norms', especially in situations where over-drinking is concerned prompting that the study of women and alcohol should therefore seek to examine women's alcohol consumption from a women-sensitive standpoint. Research has indicated that because of the lack of understanding of women's

drinking, a women- sensitive awareness of the links between women and alcohol needs to be cultivated as women's alcohol consumption appears to be still linked with women's position in society (Ettorre, 1997).

These ideas reveal the influence of gender in the consumption of alcohol, reflecting social attitudes towards women. Hegemonic discourses around reproduction infer that the women's role is that of the biological reproducers of the nation, given the 'natural role' of women to bear children (Yuval-Davis, 1996). Responsibility then falls upon women for the health of the nation and depends on the reproductive powers of women (Yuval-Davis, 1996, p.18). There are clear political implications of perceiving women as the biological reproducers of the nation as it leaves women open to stigma when they behave in a way that would not appear conducive to this. For example the onus on drinking during pregnancy as harmful has led women to therefore be perceived as risking the nation's health and are therefore constructed as 'deviant' through power and class based discourses.

The relationship between women and alcohol has been fraught and complicated, indeed RÚDÓLFSDÓTTIR and Morgan (2009) opined that femininity and alcohol were viewed as unsuitable bedfellows. In this sense, women were considered as domestic creatures who embody and represent sexuality; RÚDÓLFSDÓTTIR and Morgan (2009) argue that it is this emphasis on images of proper femininity that is put at risk by women's alcohol consumption. As Ettorre (1997, p.14) argues, women who get intoxicated threaten the traditional feminine female roles of wife and mother by putting 'their femininity and female roles in society at risk' and are perceived as being out of control. As Thom (1997b) purports; traditionally the individual drinking mother has been portrayed as something which is 'nationally harmful' and needing controlling. Moreover, Ettorre (1997) argues that women are deemed to need surveillance as they are less responsible in their drinking than men. Similarly, Lyons and Willott (2008) contend that women who are drunk in public are vilified as being deviant and slutty. The gender differences between men and women's drinking are therefore important. This research maintains a feminist perspective and seeks to apply a critical feminist lens to the discourses around women's alcohol consumption during pregnancy and FAS/FASD examining how, as Hunting and Browne (2012) indicate, dominant discourses are instilled with gendered assumptions which disseminate hegemonic power relations.

#### **2.4.2. The control of women**

According to Ettorre (1997), women are often represented as a uniform group, with differences such as age and social class glazed over. Thus, Ettorre (1997) contends it is important, in the discussion of women and alcohol, that not all women who drink are perceived to have alcohol-related problems. The work of Ettorre (1997) has been particularly important in highlighting how many women are able to consume alcohol in a positive and pleasurable way and are not alcohol-dependent or alcoholics. According to Ettorre (1997) the concept of 'positive drinking' implies that women's use of alcohol can be experienced in a positive way, focusing on moderate levels of alcohol consumption. The consumption of alcohol is therefore a pleasurable experience, acting as a social lubricant to aid relaxation. In comparison, 'negative drinking' involves drinking to excess to 'kill' or 'medicate' feelings, and frequently results in women being harmed by their over-consumption. Women who are involved in negative drinking or the misuse of alcohol risk social disapproval and rejection. Pleasurable drinking forms part of positive drinking and is therefore a controlled form of drinking, where women drink for pleasure but monitor and limit their own consumption levels (for a broader discussion of positive and negative drinking see Chapter 6). Ettorre (1989) and RÚDÓLFSDÓTTIR and Morgan (2009) argue that there is little acknowledgement of women drinking and the role of pleasure; indeed the work of Ettorre (1989) was the first time the discourse pleasure was acknowledged for women in the addiction field, and highlighted the need to recognise women's quest for pleasure. Women who drink alcohol to excess are sometimes seen as being in need of 'sending home'; this act serves to consequently remove the woman from visibility, returning her to the private arena, the home or domestic life in which control and compliance could be re-established, placing women in the more direct scrutiny of the private gaze (Ettorre, 1997). These arguments reveal how women who drink alcohol go against the feminine ideal of a well-behaved woman and risk stigmatisation. As Fillmore (1985) argues women who drink alcohol are at higher risk for victimization than men. In this instance, patriarchal control exists over women. This coincides with research by Plant and Plant (2006) which has pointed out that disapproval of women who drink is deeply rooted in most cultures. Ricciardelli et al. (2001) contend that changing gender roles have continued the trend to increase women's exposure to alcohol, social norms of

women's alcohol consumption becoming more lenient, increasing the societal expectation that women will drink alcohol. Yet I would argue that negative stereotypes still exist as women fall prey to negative stigma if they fail to adhere to standards expected of them and if they over consume.

Despite this gender differentiation, the work of Plant (2008) highlights how women are now specifically targeted as alcohol consumers, receiving messages to continue to drink alcohol at increasing levels. Indeed women are now shown to be consuming higher levels of alcohol. The gender gap between men and women's drinking in the UK has narrowed (Alcohol Focus Scotland, 2007) and in 2011 just under a fifth of Scottish women (18%) were categorized as hazardous or harmful drinkers (A National Statistics Publication for Scotland, 2012). The role of alcohol advertising in consumption is highly important (Atkin et al., 1983, Smart, 1988, Atkin, 1990). In their work Ettorre (1997) and RÚDÓLFSDÓTTIR and Morgan (2009) demonstrate how alcohol is frequently advertised as a lifestyle product and alcoholic drinks are designed, packaged and marketed to appeal to the female taste by being marketed as 'women-friendly'.

In their examination of women's relationship with alcohol, RÚDÓLFSDÓTTIR and Morgan (2009) found that many women do not feel that the negative image of alcohol consumption portrayed in the media reflected their own consumption patterns and behaviour. It can be inferred from this that some women are unaware of how much alcohol they consume, wishing not to be associated with images of drunken and disorderly women. These women 'other' themselves to 'other' drunken women through the process of 'othering'. This process of othering sees health behaviours as identity strategies, contrasting the healthy self with the non-restrained, out of control other (Crawford, 2006) and is often associated with unequal power relations (Panelli, 2004). The 'other' is used to describe someone who is different to the self, in negative ways (Valentine, 2001) or is 'polluting' or 'risky' (Lupton, 1999a). Connolly-Ahern and Broadway (2008) write that the situation is exacerbated by media coverage which can influence what issues people think about and how they evaluate them.

The 'good' mother ideology is also linked to the power discourses that exist over women. Medical surveillance has led to power being placed over women's bodies,

ensuring that women behave correctly during pregnancy to benefit the health of the child. A discussion of power and its role is important, with a consideration of biopower and the way in which women's bodies surveyed by the gaze of others. In this, I turn to the work of Foucault and co-workers (Foucault, 1976, 1979, 1991, 2000), who have examined the role of power in the medical encounter.

#### **2.4.3. Using the work of Foucault to examine Power in the medical encounter – biopower, surveillance and the gaze.**

It is postulated by Lupton (1997a) that power, as it operates in the medical encounter, is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies. It may be considered that 'the central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility' (Lupton, 1997a, p.99). Power is also viewed as relational, and a strategy that is transmitted through all social groups (Lupton, 1997a). Lupton (1997a) argues that there is always a certain level of power that exists between a doctor and a patient, but that it is continually negotiated and dependent upon the interaction.

The notion of biopower, as developed by Foucault (1976, 1991, 2000), is important to the understanding of power. The medicalisation of the body (as defined later in Section 2.6) in a new power configuration was termed biopower by (Foucault, 1979). Biopower highlights an understanding of how bodies need to be regulated and maintained, in order to ensure that bodies are normal and conforming in society. Using Foucault's notion of power, Ettorre (2008) describes how biopower aims for control over humans, as the social force producing and normalising bodies to serve relations of dominance and subordination in society. Bio-power is therefore a process that ensures embodied normativity, meaning that bodies therefore conform to normality, and is maintained in society.

This notion of biopower is important to our understanding of the consumption of alcohol during pregnancy. In her work looking at the use of drugs by women, Ettorre (2008) shows, biopower produces and normalises female bodies to serve prevailing gender relations. Female bodies are defined and shaped by their reproductive capacity, being seen as unstable, irrational and unpredictable. The concept of bio

power represents a type of domination that makes the body politically docile and accepting of power and advice. Jones and Chandler (2007) argue that this notion informs our understanding of women's bodies as contested centres locus of power.

Foucault used the concept of 'surveillance' to characterise the process by which discourses define people's understanding of the world and encourage them to conform to certain norms of behaviour (Davies and Allen, 2007). Surveillance denotes the process of exercising disciplinary power. Through their access to technical knowledge and the development of expertise, health professionals are able to shape the experience and behaviour of patients through this disciplinary power; however there is the potential to provoke resistance. Indeed, Davies and Allen (2007) consider this to be likely as non-professionals express their values and views of the world.

The intense focus on the pregnant woman's body has produced an impetus towards self-regulatory behaviour; as a self-regulated citizen a pregnant woman is therefore expected to minimise the risks to which she is exposed (Lupton, 1999b). This is not surprising as pregnancy is becoming what Handwerker (1994, p.666) defines as 'one of the most extensively documented medical conditions'. Women are therefore subject to a high level of expert surveillance and are expected to exert a continuing self-surveillance with 'subtle pressure on women to conform to expectations' (Lupton, 1999b, p.69). They are therefore expected to adhere to this self-surveillance voluntarily, and become autonomous, self-regulating citizens in order to maximise the chances of their foetus being in good health. Women are therefore expected to police their own behaviour, drawing on the arguments of Foucault, Lupton (1995) argues that the emphasis on self-regulation is evident in discourses on health and risk as there is increasing reliance on the individual for the self-responsibility for health. As Lupton (1999b, p.61) defines 'risk discourse in relation to pregnancy can be linked to the apparatus of 'biopolitics' in neo-liberal societies, efforts on the part of the state and other agencies to discipline and normalize citizens, to render them docile and productive bodies'.

At the end of the twenty-first century the pregnant woman is surrounded by a complete network of discourses and practices directed at the surveillance and regulation of her body. No longer a single body, but one

harbouring the potentiality of another human, the more obviously pregnant a woman becomes, the more she is rendered the subject of other's appraisal and advice

(Lupton, 1999b, p.60)

The work of Michael Foucault is highly relevant to the surveillance of women, through the concept of the medical gaze, a 'way of seeing' that provides a regulatory role over women by doctors. The 'medical gaze', 'at once a perception but also an active mode of seeing' represents 'the process through which specific social objects, namely disease categories, come into existence and how more recent shifts can be seen as changes in the gaze' (Armstrong, 1997, p.21). The 'gaze' is entwined with different notions and forms of power and is one of the functions which the medical profession use to enable social control (Davies and Allen, 2007). As Turner (1987, p.11) identified 'the clinical gaze enabled men to assume considerable social power in defining reality and hence in identifying deviance and social order'. The deployment of the gaze is argued to be an integral part of power, viewing 'the patient in this sense is no more than a container for the lesion' (Armstrong, 1997, p.22). Lupton (1997b) argues that the human body is understood through the 'clinical gaze' exerted by medical practitioners but that the gaze is not about one group seeking domination over another group. This, however, is contested through the idea that the patient caught in the clinical gaze is a 'docile body'. The concept of the 'docile body' infers that the patient caught in the clinical gaze is powerless and submissive, therefore giving the clinician immense power over the patient. The work of Braidotti (1994) uses the idea of Foucault in the discussion of the 'scopic drive' which is linked to both knowledge and control used to make the invisible, visible 'the biomedical quest to make the unseen visible in the biotechnological world' (Ettorre, 2002, p.5). The 'scopic drive' therefore is the process by which all is surveyed and pressed into normality or disciplined or ostracised.

As previously examined in Section 2.2.1, motherhood is a time when women experience heightened surveillance. The transition to motherhood is highly regulated and monitored but is also experienced as a very private and personal transition, which requires self-surveillance and personal policing of a self (Miller, 2005). Public health promotion valorises some groups whilst marginalizing others (Lupton, 1995)



and highlights the appropriate ways of becoming a mother through shared assumptions and stereotypes. When examining power it is noted that there is often resistance to it. There is thus opposition to the 'god-like powers' (Phoenix et al., 1991, p.74) that the medical profession has. In this sense, control over bodies is therefore never complete, for example the choice of a woman to have a natural birth at home, without medical supervision would class as resistance to the power that expert's hold and the expectation that labour should be conducted within a medical setting under medical observation and power. Consequently, as Foote and Frank (1999) expounded not only is power directed first and foremost towards the body but also resistance to it begins in the body. The 'good' mother ideology has led women to conduct self-surveillance, in order to ensure that they conduct motherhood in the correct manner but this is not to say that some women resist the surveillance and biopower placed on them.

Despite the power relations between the doctor and the patient Lupton and Fenwick (2001) recognise that power is not always repressive, it can also be productive creating forms of knowledge and self-empowerment. When women seek guidance and assurance there is therefore an increased engagement with the expert bodies of knowledge (Miller, 2005). Davies and Allen (2007) argue that the positive use of power through the surveillance of health professionals over bodies exists. This is often neglected as there is a tendency to:

Neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximise their health status and avoid physical distress and pain

(Lupton, 1997b, p.97)

The consequence is therefore that there is engagement with the expert knowledge of the professionals. Not all people challenge the power of the medical profession. Miller (2005) contends that women chose to engage with the medicalisation of motherhood by choosing to have their birth in the regulated environment of the hospital, under the care of doctors. Other health recommendations are also engaged with, for example as women choose to follow the guidelines for taking folic acid.

Some women actively seek high degrees of professionalism and expertise to validate their mothering practices, or seek discourses from other sources such as books.

## **2.5. INCREASING STATE INTERVENTION IN MOTHERHOOD**

Lupton (1997a) considered that medicine is a dominant institution within western societies and now plays an increasingly important role in everyday life. The way in which different states survey mothers is therefore important for the discourse of motherhood. Lawler (2000) expanded this concern noting how the State takes an explicit interest in ensuring that the needs of children are met by assessing 'good' (enough) mothering. The increased state surveillance ensures that 'women turn to the 'experts' – both medical and psychological professionals – for the definition and understanding of motherhood' (Phoenix et al., 1991, p.84).

Increasingly women are subject to heightened social controls. Researchers such as Upton and Han (2003) recall how many other institutions and social settings alongside the state construct the discourse of motherhood, which include for example the media, common culture, the family and peers etc. As an example, mass media campaigns emphasise particular subject positions and are important to how individual responsibility is negotiated (Thompson and Kumar, 2011). It is apparent that the pregnant body is increasingly becoming the grounds of medical experts. Pregnant women as medical subjects therefore lose individual identity and power as they are viewed as sick and in need of treatment, threatening to erupt or leak at any moment, bringing the inside of the body out (Longhurst, 2000a).

## **2.6. MEDICALISATION OF MOTHERHOOD**

Popay and Williams (1996) argue that the study of public health has been dominated by the medical profession. Historically, women had been treated as experts in the role of childbirth as the role of midwives was greatly linked to supporting women during labour. Oakley (1976) observes that the inclusion of obstetrics in the curriculum of professional medical training, led to the de-valuation of midwives by the medical profession, resulting in the male dominance of the medical profession and male control over birth. Oakley (1976) understands that it was realised that the physical condition of mothers impacted upon infant mortality rate and the creation for a school for mothers in 1907, which marked out the idea that motherhood had to

be learnt and presented women as agents of reproduction and little else. This was synonymous with the moves towards the hospitalisation of childbirth and the state regulation of midwives and the increasing role of medicine in reproduction (Doyal, 1983). Alcohol is therefore linked with the debate over genetic screening as state intervention seeks to protect the normality of future generations (Harris and Paltrow, 2003, Campbell and Ettorre, 2011).

### **2.6.1. Pregnancy as a Conflict. Examining the rights of foetus versus rights of the mother**

Academics have argued that risk is a central discourse during pregnancy, indeed as Lupton (1999b) argues, the advice that women receive is directed at containing risks that are viewed as threatening to their own health, but also increasingly those which are threatening the wellbeing of the foetus. As previously identified, alcohol consumption during pregnancy is associated by some with the concept of 'bad' mothering and is in some cases perceived as a form of maltreatment to the foetus as expert discourses represent the unborn child as vulnerable (Lupton, 1999b). The increasing medicalisation of motherhood and women's bodies, has led to women being reduced to the maternal environment (Rothman, 2000) for the foetus. Oaks (2000) argues that this has coincided with increased attention to how the behaviours of pregnant women such as alcohol consumption, cigarette smoking and drug use, negatively affect the health of the foetus. An examination of the maternal-foetal conflict is therefore important (Chavkin, 1992, Gallagher, 1987).

As the maternal-fetal relationship is open to public surveillance and regulation, pregnancy is therefore seen as a potential time for conflict (Oaks, 2000). Seeing the child as separate from the mother has been possible through the increased use of ultrasound and other medical paraphernalia, with technology increasingly facilitating the medical profession to see the child and the mother as two separate patients (Oaks, 2001, Casper, 1994). This concept of the 'Public foetus', is therefore the object of externalised mechanisms of surveillance and regulation, with a shift towards an emphasis on foetal risk consequently having significant implications on the experience of pregnancy (Lupton, 1999b). As Oaks (2000, p.64) argues, this 'proliferation of fetal representations that establish the fetus as an actor who lives beyond the boundaries of a pregnant woman's body and inhabits a privileged place in

the public imagination'. In this sense women are losing their rights over the increase in the attention paid towards the rights of the foetus and the increasing view of the foetus and mother as having an antagonistic relationship. Ruddick (2007a) argues that this argument portrays the mother's body as a weapon or a 'theatre' for the pregnancy' and engages with the question as to what rights does a mother have over her body whilst pregnant. It has even been argued that alcohol consumption during pregnancy is therefore 'child abuse in the unborn foetus' (Apolo, 1995, p.214). The body is the site of power struggles and is constructed in certain ways, yet this argument sees women's bodies as vessels or merely a container for the child and is therefore negative and limiting towards women's bodies, defining them only in their reproductive terms (Jones and Chandler, 2007).

As this research reveals, the pregnant body is seen as an ecosystem for the foetus (Elvey, 2003). The 'fetus has become invested with a individual identity apart from that of the mother' (Lupton, 1999b, p.62), viewing the pregnant woman as a maternal environment for the foetus. Handwerker (1994, p.668) also asserts that the foetus is 'now viewed as a separate and technically interesting patient' having a set of risks distinct from the health of the mother. Increased medical paraphernalia has helped to unveil the foetus to observation (Fasouliotis and Schenker, 2000, ACOG, 2005). The medical model of the maternal-foetal relationship has shifted from unity to duality as they are now seen as two separate patients with two differing sets of needs (Fasouliotis and Schenker, 2000) and presents them in an antagonistic relationship (ACOG, 2005). The foetal image is now a regular part of culture (Casper, 1998), has independence (Braidotti, 1994) and is used for political purposes (Lupton, 1994). This has been made possible through the use of ultrasound technology, which is now embedded in 'normal' pregnancy (Draper, 2002).

However the idea of the knowing foetal subject positions the foetus as an independent subject, therefore marking the mother as a 'mere backdrop', ensuring that there needs to be regulation and surveillance of women's bodies during pregnancy (Ruddick, 2007a). This marks out the mother's body as a hostile terrain for which the mother is responsible. Yet as Ruddick (2007a, p.514) expounds 'the foetus, however, as a (*de jure*) impossible subject cannot speak for him/herself without adult authorisation. Therefore it cannot be assumed that 'any representation of the child is inherently more progressive than another' (Ruddick, 2007a, p.516) as

the child cannot legally speak. Ruddick (2007a, p.638) argued that giving the foetus increased rights over the mother creates a 'ventriloquist form of representation'. This portrays a mother as a potential source of harm which babies need protection from. This presents a conflict of rights between those of the mother and those of the unborn child, similar to work seen in the anti-abortion crusade. Maternal autonomy has long been debated within abortion politics (Fasouliotis and Schenker, 2000). Attention therefore needs to be paid to how women's rights are being addressed:

We do not have to consider the fetus as a separate, alien being, locked in its mother's body, a patient we cannot reach without going through the mother. Nor do we have to consider the mother as a fetus container, a walking environment without social context. Women and their foetuses are bound together and enmeshed in a social world

(Rothman, 2000, p.61)

We need to be aware of what these constructions say about pregnant women's agency. These arguments therefore position the mother as having an aggressive relationship with the foetus. Despite this separation, the pregnant woman still remains responsible for the foetus' wellbeing, 'her body therefore is constructed as doubly at risk, and she is portrayed as doubly responsible' (Lupton, 1999b, p.63). As Handwerker (1994, p.672) argues the 'humanification of the fetus makes a woman's role not only more public but increasingly out of her control'. This defines the mother as exclusively responsible, and establishes her in an antagonistic relation to the foetus (Ruddick, 2007b). Similarly as Longhurst (1994, p.220) purports 'it is widely believed that a pregnant women's primary concern ought to be for her unborn child, the pregnancy in many ways does not belong to the woman herself'. It is made evident, therefore that responsibility is with the mother, with pregnant women becoming encouraged to be 'highly vigilant in their policing of their bodies so as to ensure the health of their foetus is not compromised by their own actions' (Lupton, 1999b, p.64). Consequently more responsibility for life outcomes is placed on the individual, negative outcomes are therefore viewed as the fault of the mother, as 'the woman who fails to heed expert advice is portrayed as posing a risk to her foetus' (Lupton, 1999b, p.66).

Rothman (2000) and Oakley (1979) contend that the professionalization of medical discourse led to the medical authority becoming male-dominated, and this does not serve the interests of women. Certainly, Phoenix et al. (1991) assert that the professionalization of motherhood and expertise claims to knowledge are frequently from men and doctors. This concurs with the work of Schofield et al. (2000) who discuss how medical services have been described as frequently being male-dominated, focusing on patriarchy and the subordination of women. Feminist critics such as Lupton (1997b) have viewed the medical profession as a patriarchal institution which maintained the inequality of women by drawing attention to their susceptibility to illness and taking control over areas of women's lives such as pregnancy and childbirth. The male-dominated medical authority acts as a patriarchal institution which interferes with pregnancy and labour because it treats women as not 'good' enough at mothering (Lupton, 1997b, Oakley, 1976). Oakley (1993) asserts that women need to be experienced as central actors in childbirth and motherhood, a development that cannot be achieved with the current male-dominated state of medicalisation.

Women during childbirth are portrayed as being ill and in need of medical intervention, as Oakley (1979) infers women are not aware of what is in their best interests. It is evident from the writings of Oakley (1976, 1979) and Lupton (1995, 1999b) that childbirth has become increasingly reliant upon medical interventions; indeed labour has become more unnatural. The benefit of this to the mother is contested. The use of 'technological paraphernalia' has led to the 'colonisation of birth by medicine' (Oakley, 1979, p.15) with increasing power being placed over women's bodies, resulting in women facing a loss of control. In Oakley (1980) 'Women Confined' and 'The Captured Womb' (Oakley, 1984) alongside the work of Stanworth (1987) 'reproductive technologies' outline the increasing reliance on medical technology during childbirth. Again, this implies that the mother is docile and is submissive to the medical discourse, yet as explored earlier, often resistance emerges against power. It is evident that the mother/child dyad is the primary focus of the regulatory gaze of state agencies as motherhood becomes constructed through state and medical intervention or other dominant authoritative knowledge.

The critique of medicalisation by Oakley (1980, 1984, 1993) and Lupton (1995, 1994, 1997a) on motherhood is important to this debate. Subsequent researchers,

e.g., Rothman (2000), argue that the process of the medicalisation of motherhood, that sees pregnancy and of birth as medical events, does not serve the interests of women. Medicalisation has led to the treatment of the mother and child as two separate patients, additionally treating reproduction as a medical condition in need of management. This medical discourse views pregnant women as unhealthy bodies in need of medical treatment. Longhurst (1999) examines the way in which pregnant bodies threaten to leak and add disruption. The multiple constructions of fetal personhood has, therefore, been questioned with a turn of feminists to encourage support of women's reproductive rights (Rothman, 2000, Rothman, 1993 1993, Morgan, 1996, 1997, Oaks, 2001, Casper, 1994, 1997, Conklin and Morgan, 1996).

Ettorre (1997) contends that the continual monitoring and medical intervention over women during pregnancy removes women's reproductive powers, by defining pregnant women through symptoms and diagnoses. This aligns with the work of Oakley (1984) who found that women come to be seen as unhealthy when they are pregnant and in need of medical intervention. Research by Longhurst (2000a) reveals that the power women hold over their own bodies is reduced, as pregnant bodies even threaten to leak, and dominant discourses see pregnant women as less intelligent or rational (Longhurst, 1997). In line with this argument Oakley (1984) contends that pregnancy no longer becomes seen as a natural process but instead an illness, and an unhealthy state in need of medicalisation and medical intervention implying that women are sick and in need of some form of control. Furthermore, women appear as being incapable of protecting their own bodies during pregnancy (Ettorre, 1997). Ettorre (1997, p.103) recognises that women become highly observed and scrutinised after they become pregnant, and that their bodies 'become the official testing grounds of the medical profession'. In this sense pregnancy tends to be accepted more as a female illness than a normal life event for women. This impacts a woman's experience of pregnancy as they become a body colonised by a foetus, or women's bodies become resources to reproduce the men's world (Ettorre, 1992). This usual medicinal ideology used when discussing pregnancy and alcohol consumption, as purported by Ettorre (1997) categorises pregnant women as both unhealthy and in need of treatment and almost infers that women cease being women and become only a medical subject in need of treatment. Ettorre (1997, p.104) argues that pregnant women especially those who are alcohol dependent, are therefore seen

by the medical profession as ‘doubly sick’, due to being pregnant and their addiction to alcohol.

The medicalisation of motherhood has thus served to monitor and observe women and has led to an increased dependence of women upon medical knowledge. The work of Lupton (1997b) also concurs with this and adds that being medicalised is not a desirable state of being, that it should be resisted, as Oakley (1980) argues it changes the experience of reproduction making dependence on others a condition in its achievement.

The increasing medicalisation of motherhood ties into the theory of governmentality (Foucault, 2000, Petersen, 2003) which sees the key focus of governments on the improvement of population health, as a benefit to the state, society and the individuals themselves (Thompson and Kumar, 2011). The concept of motherhood in this sense invests responsibility on mothers to prevent their children from harm. Governmentality theorists argue that subjects are ‘governed at a distance’ by being incited to govern themselves (Thompson and Kumar, 2011, p.107) thus appealing to a person’s individual sense of responsibility and as Petersen and Lupton (1997) argue resulting in the stigma of those who appear unwilling to engage in health-enhancing activities. This stigma or other negative consequences will therefore occur if individuals do not choose to follow the health guidance which they are given, and they will be perceived as deviant.

### **2.6.2. Motherhood and the Incompatibility of Drug Use and Alcohol with Reproduction**

As previously examined women’s alcohol consumption has strong links to femininity and the way in which work in the private sphere is valued. A woman’s role in looking after the family is of moral significance because, as Ettorre (1997, p.90) opined ‘the family is viewed as the basic emotional and economic unit in society, and an over-drinking wife and mother unable to cope with her domestic duties can be considered a threat to that’. This illustrates that there is a strong link between women’s alcohol consumption and the notion of a ‘bad’ mother. Women who drink alcohol are therefore unable to fill the societal expectations of them (See previous definition of ‘good’/‘bad’ mother in Section 2.2.1). Studies have shown that drinking patterns are typically linked to stages of life (Plant and Plant, 2006, Paradis,



2011, Christie-Mizell and Peralta, 2009). Parenthood, or more specifically motherhood, and the consumption of alcohol are often perceived as incompatible, with motherhood considered to represent a stage of life quite distinct from single, social drinking days. This is in line with how motherhood tends to be publicly conceived. In their study on men's and women's accounts of drinking in early mid-life, Emslie et al. (2012) found that alcohol consumption was dependent upon the life course position, as individuals begin to plan their alcohol consumption around responsibilities such as children. They also indicated that some people were critical of mothers who consumed alcohol whilst caring for children (Emslie et al., 2012). As Ettorre (1997) argues it is desirable to abolish the negative images of women's drinking as these images place a stigma on women which can be hard to move beyond.

There are values set by society that indicate how women, especially pregnant women, should act or behave. Due to the increased awareness of the negative effects of alcohol consumption during pregnancy, women who consume alcohol during pregnancy have now become the most stigmatised group of women. Women who step 'out of line' by consuming alcohol whilst pregnant, or by going against any other health advice offered are often stigmatised. Ettorre (2007) comments that drug use is a drug user's main disability and that this disability is a moral one, with women drug users having fewer rights than their male counterparts, especially if they are pregnant. Although this comment is about drug use, it has parallels with alcohol consumption as alcohol is increasingly being treated itself as if it is an illegal drug as drinking is becoming a more stigmatised activity, a behaviour which is being increasingly condemned by the media within the UK. Increased media attention has led to a growing attention/awareness of alcohol during pregnancy (Bennett, 2007, Child, 2012, Geddes, 2012, Johnson, 2007, Moran, 2007, Mosley, 2013, O'Reilly, 2010, Rose, 2007, Daniels, 1993, BBC, 2012). In line with the argument of Ettorre (1997, p.104) it is then unclear 'whether the growing interest in women's alcohol consumption during pregnancy reflects a genuine medical concern or if it is a 'political' matter which can be conceived as another way of extending the medical profession's control over women's bodies'. Increasingly, women are receiving powerful messages about alcohol consumption during pregnancy (National Collaborating Centre for Women's and Children's Health, 2008, NICE, 2008, NHS

Health Scotland, 2009) which could be deemed an attempt to control pregnant women's relationship to alcohol. In the issue of a policy change to abstinence, Lowe and Lee (2010, p.302) highlight that the lack of supporting data and therefore 'uncertainty in the field of scientific evidence was interpreted in this instance not as a reason to eschew abstinence advocacy but apparently as a reason to support it' consequently this 'sets out a new approach to risk based on seeking to make uncertainty certain' (Lowe and Lee, 2010, p.306).

The introduction of the recommendation for abstinence has made it increasingly morally unacceptable to consume alcohol during pregnancy and assists in these powerful messages to affect the notion of the 'bad' mother. For those women who do choose to consume alcohol they face high levels of stigma or risk being portrayed as 'baby destroyers' (Ettorre, 1997, p.107). This moral crusade against pregnant women as described by Ettorre (1997) increasingly puts pressure on women to abstain from alcohol or risk stigma. The work of Longhurst (1994, p.119) also related to this, revealed how by behaving inappropriately, women are going against the unwritten cultural rules of pregnancy, and find that their behaviours become 'increasingly socially unacceptable the more visibly pregnant they became'.

Following the argument that drug treatment systems were originally designed to meet the needs of men, Ettorre (2007) argues that treatment has been slow to change to meet the needs of women (see also Campbell and Ettorre (2011)). The argument of Ettorre (2007) is that women in these systems are considered to be at a greater disadvantage because of the predomination of 'masculinist' (i.e., male privileging) and paternalistic structures rather than gender-sensitive structures (Carter, 2002). This situation is similar to the way in which alcohol treatment services have developed for women. Existing facilities have been unable to meet the needs of women because the services had been developed with male alcoholics in mind (Thom, 1997b). Yet their traditional gender roles mean that women have different needs for help.

Society sets conditions for the reproduction of bodies (Ettorre, 2007) and bodies that don't fit this are deemed to be faulty or defiant. This idea of a 'faulty' body is relevant to the ways in which researchers examine how a pregnant body is observed to be a body out of control and needs to be regulated. Discourses around the

promotion of health have shaped the body indicating that the state must deal with bodies that are 'faulty'. As previously examined, there is, especially in America, increasing government intervention in pregnancy, emphasising the needs of the foetus as superior to the rights/needs of women which results in discouraging women from seeking substance abuse or prenatal care because of the risks of stigma (Paone and Alperen, 1998). Leppo and Hecksher (2011) argue, for example, that the perception of the risk of Foetal Alcohol Spectrum Disorder (FASD) relates to the prominence of risk calculation in late modernity. This term of 'embodied deviance' as noted by Ettorre (2004, p.330) is shown to be 'the scientific and lays claim that bodies of individuals classified as deviant are marked in some recognisable way'. Informing women about the risks of prenatal drinking provides an example of risk management which builds on individual choice and agency. There is a danger in this approach that the factors that contribute to women's well-being and shape their consumption of alcohol are forgotten. This will lead to an increase in moralising and punitive attitudes towards pregnant women (Leppo and Hecksher, 2011, Greaves and Poole, 2005). The argument of Campbell (2000b) on the notion of governing mentalities which are linked to social morality in the USA about drugs I would argue is also relevant to the debate around alcohol consumption during pregnancy.

However both drug use and alcohol consumption are portrayed as incompatible for reproduction. For example this is evident in the ways that the media have vilified women for consuming alcohol during pregnancy and stigmatised women for these behaviours. Such concepts are supported for instance by Ettorre (2007, p.31) who states 'for drug users, reproduction becomes a complicated body issue because drug use is not seen as conducive to making babies or even supportive of family life'. Women's bodies are therefore seen as a threat to the unborn foetus. The person who uses drugs or consumes alcohol is, therefore, not seen as an appropriate body for pregnancy, again as emphasised by Ettorre (2007, p.31) 'the medical construction of their bodies as toxic to their foetuses applies to all drug-using female bodies'. Drug use is therefore not seen as socially acceptable during pregnancy and women's alcohol consumption during gestation is being put under the same spotlight and given the same social stigma. Women who take drugs or consume alcohol during pregnancy have their bodies viewed as not fit to reproduce by the regulatory regime. In this light 'the pregnant drug-using body is constructed as a deviant body, a

discursive construct which is separated from other female bodies and deciphered by experts as being immoral, inferior, disgusting and ‘out of order’ (Ettorre, 2007, p.91).

The ideal body for pregnancy is therefore a conforming body that allows itself to be regulated by the medical profession and undertakes the guidance given to it, ‘doing pregnancy in approved ways’ (Ettorre, 2007, p.111). It is obvious that drug use or alcohol consumption during pregnancy is not perceived as compatible with this. Obviously an addict who is pregnant is perceived as being incapable of regulating her own health and behaviour (Ettorre, 2007). Yet as Irwin (1995) argues the desire for a positive foetal outcome may exist for many, if not all of these women.

### **2.6.3 Pregnancy and alcohol a deviant behaviour**

Bodies that use drugs or consume alcohol during pregnancy, place a threat to the foetus, and therefore fall short of this ideal body and the ‘good’ mother. The pregnant body is constructed both as a docile subject and as an active agent but the use of alcohol or drugs contrasts this. For women that drink during pregnancy, their behaviour is viewed as immoral and possibly detrimental to the health of their unborn child. These women are therefore stigmatised for their health behaviour. For women that consume alcohol during pregnancy, this may be the first time that they have experienced stigma within their lives. As Plant and Plant (2006, p.30) examines ‘the hand that rocks the cradle should not be a shaky one’ and for women that drink their behaviour is consequently seen as ‘deviant’ and morally unacceptable. Alcohol consumption during pregnancy is therefore a highly stigmatised behaviour and even legally punishable in some parts of the world. The cultural representation of pregnant women is one of vulnerability and in need of protection. Pregnant women who use drugs or alcohol are perceived as putting their bodies and foetuses at risk; ‘the pregnant drug user embodies this risk’ (Ettorre, 2007, p.96). This idea infers that when a woman becomes pregnant her moral character is drawn into question. The use of alcohol during pregnancy leads to women being considered as ‘unfit’ mothers (Salmon, 2004) who are not only threatening to their children but because of the emergence of FAS as a moral panic, are now thought to be a social problem presenting a threat to the state (Humphries, 1999). This moral panic, expounds that the threat is everywhere, leading to the social control of women. As Salmon (2004,

p.116) argues ‘moral panics reify differences between the subjects of the panic and those constructing them. This process is also referred to in feminist and anti-racist scholarship as “othering”. The subjects of panics are rendered objects of pathology, deviance, or blame’. This therefore renders women who are defined as ‘at-risk’ for the consumption of alcohol during pregnancy, to be singled out for blame and as objects of ongoing surveillance.

Golden (2000) argues that the moral panic, which emerged surrounding women’s crack cocaine use, introduced a notion that it was in the public’s interest to begin to control the behaviour of pregnant women. Moral panics have been linked to the increased attention they are given by the media (McRobbie and Thornton, 1995). The imagery used around crack babies focussed on the use of drugs on foetal health (Roberts et al., 2012, Murphy and Rosenbaum, 1994). Like drug use, the use of alcohol during pregnancy is viewed by some as a challenge to ‘the ‘sanctity’ of motherhood’ (Paone and Alperen, 1998, p.105). Women who do these behaviours are therefore perceived to be unfit mothers viewed as immoral rather than reflecting an understanding which views drug use as resulting from an illness (Paone and Alperen, 1998). This reflects what Thompson and Kumar (2011) define as the tendency to divide citizens into the deserving and undeserving. In this sense the concern focuses on individual morality and personal responsibility. This is interesting as alcohol is being increasingly likened to drugs use, yet alcohol use is not illegal but is becoming stigmatised in the same way as drugs are in pregnancy. The emphasis on the behaviour has now led to pregnancy no longer being viewed as a natural process; instead it has become instilled with the moral expectations of motherhood. This in turn gives the foetus agency and limits women’s autonomy (Oaks, 2001). The medicalisation of everyday life therefore encourages the moral pursuit of healthy lifestyles (Crawford, 1980). Women are therefore expected to be selfless in their health choices (Daniels, 1993). ‘Good’ mothers are therefore selfless and make decisions for their unborn child over their own desires.

#### **2.6.4. Surveillance of pregnant women who drink during pregnancy**

The advice given to pregnant women is therefore ‘healthist’ and is enforced by pregnancy policing (Oaks, 2001). This utilises theory around ‘healthism’ as purported by Crawford (1980) that sees a preoccupation with personal health as a

moral responsibility. Drinking during pregnancy is therefore constructed as a public health and social problem, which in turn leads women who consume alcohol during pregnancy open to stigma.

There is an increasing visibility of drinking during pregnancy which highlights that the discourses surrounding alcohol consumption are very mixed, varying between messages of abstinence and for low level of alcohol consumption. In the public eye, celebrities are now being stigmatised for their choices around alcohol consumption during pregnancy. For example, Oscar-winning British actress Rachel Weisz sparked a debate worldwide on the consumption of alcohol during pregnancy when she told a group of reporters that she considered it acceptable for pregnant women to drink alcohol, and that drinking wine was “fine” after the first trimester of pregnancy (Connolly-Ahern and Broadway, 2008, Munro, 2006). Actress, Gwyneth Paltrow also admitted she drank Guinness and was spotted sipping red wine while pregnant (O'Reilly, 2010). Similarly actress Kate Hudson was vilified for sipping white wine during pregnancy while out for a meal (Weiss, 2011). These instances highlight the increasing debate on the acceptability of maternal alcohol consumption during pregnancy and represent the ways in which women are surveyed during their pregnancies, and in some instances stigmatised for their health behaviours. Most recently a photo was also posted on the social networking site Twitter by celebrity Kim Kardashian, drinking what appears to be a glass of wine; this led to a ‘twitter storm’ (Hookem-Smith, 2013) and subsequent debate on drinking alcohol during pregnancy. Although pregnant at the time of the picture being published, it appears that the photo was old, and taken before she was pregnant. However it led to a stream of comments reflecting the different prevailing attitudes towards women’s alcohol consumption during pregnancy. In an article by Hookem-Smith (2013), Dr Sneh Khemka, medical director at Bupa International is quoted as commenting:

There is a stigma (around the consumption of alcohol during pregnancy) and it’s an appropriate stigma...Drinking in pregnancy is generally not a good idea and there's a reason we stigmatise it...Generally as a rule of thumb, don’t do it...And certainly don’t drink in first three months. It's the liver that breaks down alcohol and it takes quite a long time to form in a growing baby, so particularly in the early stages it can't process any alcohol drunk by the mother...After three months it’s fine to have an

occasional drink but it's important to realise that this really is occasional - maybe at Christmas or on a birthday. You can drink up to one unit in a week and two is acceptable but it shouldn't be an every-week thing.

(Hookem-Smith, 2013)

The responses to these articles indicate that for some abstinence from alcohol during pregnancy is becoming a social construct and that this issue engenders emotion. Portraying these celebrity mothers as dangerous and posing a threat to their foetus, they also highlight the unfaltering stigmatisation of women that consume alcohol during pregnancy by a selection of the population.

#### **2.6.5. Pregnancy as an Opportunity for Change**

In their study into socio-economic life-course influences on women's smoking before, during and after pregnancy, Graham et al. (2010) found that parity was important, having a first child increased the odds of quitting in pregnancy and remaining a non-smoker. This further highlights the consensus that becoming a mother acts as a catalyst for positive lifestyle change for all women (Graham et al., 2010). Pregnancy therefore provides an opportunity for quitting smoking, irrespective of social background. It can be argued therefore that pregnancy is an important time for change, not just for quitting smoking but for other health behaviours too.

#### **2.7. WOMEN AND ALCOHOL. THE CONSUMPTION OF ALCOHOL DURING PREGNANCY**

Prochaska et al. (2011) report that the majority of pregnant women consider a behavioural change when a health risk is presented to their baby. Although no maximum level exists that can be regarded as safe to the foetus or the expectant mother, there is no conclusive evidence to show that a small amount of alcohol consumption does indeed harm the foetus. Ettorre (1992) also argues that the increasing attention paid to the taboo of women's alcohol consumption is also because of the control of women. Ettorre (1992) emphasises this point by highlighting that the literature around the risk of testicle shrinkage (testicular atrophy) amongst heavy drinking men is non-existent, therefore that the message on FAS is about controlling women's sexuality as much as it is about preventing foetal

harm (Ettorre, 1992). There is still 'no known' safe level of alcohol use while pregnant. Marchetta et al. (2012) conclude that, because of this, the consumption of alcohol during pregnancy remains a public health concern. The guidance provided by The Scottish Government on the consumption of alcohol currently states:

Our advice is that women who are trying to become pregnant or are pregnant should avoid drinking alcohol. There is no 'safe' time for drinking alcohol during pregnancy and there is no 'safe' amount

(The Scottish Government, 2013, p.1)

The UK government recommends that abstinence from alcohol should begin prior to conception (Department Of Health, 2008). Expectant mothers within Scotland are being encouraged to abstain completely from alcohol while they are pregnant and even when trying for a baby (NICE, 2008).

Rates detailing the number of women that consume alcohol during pregnancy differ. This is as to be expected given the issues around the self-reporting on alcohol and also the added possible stigma of admitting to having consumed alcohol during pregnancy. Within the USA, the findings of the Pregnancy Risk Assessment Monitoring Systems (PRAMS) (Beck L et al., 2003) suggest that more than half of women in the survey reported some amount of drinking during early pregnancy (Edwards and Werler, 2006). Indeed MacKinnon et al. (1995) found that a substantial proportion of Americans do not consider light drinking during pregnancy to be hazardous. PRAMS findings were that that 1 in 10 consumed eight or more drinks per week or had more than four drinks at a time, indicating that women are still drinking alcohol at a time where they could possibly cause deleterious effects to the foetus. These findings are similar to those of Abel (1998b) who found that a similar percentage of US women drink prior to and during pregnancy. These values were 68% and 49% respectively (Abel, 1998b). Comparable levels of alcohol consumption in France were reported by Malet et al. (2006), where the figures were similar between occasional consumers during pregnancy (33.5%) and the general female population (40%). Findings obtained from Moscow (Chambers et al., 2006) showed that 20.2% of drinking women reported at least one episode of 5 or more drinks around the time of conception and 41.1% of drinking women reported at least one episode of 3 or 4 drinks during that same time period. Malet et al. (2006) discuss



that 53% of women in France declared total abstinence during pregnancy, 32% had 1-4 units on a monthly occasion and 1% declared having 5 or more units per occasion. In France, it is recognised that the daily consumption of alcohol by pregnant women is slightly less than the level of consumption found within the general population (Malet et al., 2006). Among the women who drank during pregnancy, the amount of alcohol consumed differed greatly.

Within the UK, Murray-Lyon (1985) found that 4.8% of mothers drank in excess of 50g of alcohol daily. Findings from Scotland (Plant, 1984) indicate that the majority (70.8%) of women reduced their alcohol consumption during pregnancy; however 1.3% of the women in the study reported that their consumption of alcohol increased during pregnancy. It is concerning that within this research some women reported consuming a higher level of alcohol during pregnancy than their previous levels of consumption. From analysis of the Growing up in Scotland survey, it is apparent that 1 in 4 women consume alcohol during pregnancy (Ford, 2008); contrastingly data for Scotland from the Infant Feeding Survey (NHS, 2007) suggest that 54% of women drink whilst pregnant. McAuley (2009) however contends that despite this; the levels of consumption appear to be low with only 8% of mothers reporting drinking more than two units per week on average. It is therefore clear that across different countries there is a large difference in the number of women who abstain from alcohol completely during pregnancy. The findings clearly show that across the UK and within Russia and France, many pregnant women still continue to consume alcohol during pregnancy. This may be indicative that some women are not aware of the risks that are involved with alcohol consumption or chose not to comply with health recommendations.

Ethen et al. (2009) find that among women who chose to consume alcohol during pregnancy, the frequency and amount of consumption declined over the course of the pregnancy. This was also indicated in the findings of Malet et al. (2006) within France. In comparison, Kelly et al. (2008) find that mothers who reported having planned their pregnancy were slightly less likely to be moderate (5.2%) or heavy/binge drinkers (1.8%) compared with mothers who had unplanned pregnancies (6.7% and 2.7% respectively). Barrison and Wright (1984) argue that, from research within the UK, drinking that takes place prior to conception and during early pregnancy appears to be most damaging as many women are not

diagnosed as pregnant until 8-12 weeks after conception. The amount of alcohol a woman drinks around the time of conception and during the first trimester could potentially be influenced by the time it takes for her to recognise that she is pregnant.

In their study, Parackal et al. (2009) found more than half of the women sampled were of the opinion that it was safe to drink some alcohol in pregnancy. Some researchers argue that the percentage of women who continue to consume alcohol during pregnancy is unacceptably high (Tsai et al., 2007, Osterman and Dyehouse, 2012). It is obvious; however, that many women are still continuing to consume alcohol during pregnancy and Jesuratnam et al. (2011) argue that it is unclear if women are aware of the new guidelines. It is evident that many women are continuing to consume alcohol during pregnancy despite warnings from health professionals. In the majority of American studies on FAS it is clear that drinking tends to decrease during pregnancy in both amount and frequency (Church and Abel, 1998). Nonetheless, women are still choosing to consume alcohol at a time which could be detrimental to foetal health.

After a concentration on alcohol and its role in the night-time economy (Moore et al., 2007); urban drinking spheres (Jayne et al., 2006, Chatterton and Hollands, 2003); club cultures (Thornton, 1995) and the associated violence (Barton and Husk, 2012, Bellis et al., 2012), there has been a turn to examine alcohol in the rural environment (Leyshon, 2011). Increasing interest is being paid towards the role of alcohol within rural communities (Valentine et al., 2008), men's rural drinking (Campbell, 2000a) and the nature of rural lifestyles and the impact these have on the consumption of alcohol. The spatial distribution of levels of alcohol consumption, is therefore important as the rural landscape is the antithesis of the urban one (Cloke, 1999). I agree with Valentine et al. (2008, p.29) who argue that cultures of alcohol consumption are 'socio-spatially differentiated practices', consequently the Importance of the geography of drinking cultures needs to be recognised.

Because of this increasing attention being paid to rural drinking, I thought it was important in my examination of drinking during pregnancy too see if it had an urban/rural difference (for further details see Section 3.7.1.). The choice to use two study sites, was also influenced by findings from the growing up in Scotland study (Ford, 2008) which indicated different drinking patterns exist during pregnancy in

urban and rural locations. The Growing up in Scotland data set is a longitudinal study commissioned by the Scottish Government Education Department. Logistic regression modelling of the Sweep 1 data set revealed that a quarter of all women reported consuming alcohol in pregnancy. Alcohol consumption was reported to be slightly higher within rural areas within the survey where 33% of women reported drinking alcohol during pregnancy (Ford, 2008). High amounts of drinking and health related problems are reported within rural areas of Scotland. This rural effect therefore needs to be examined further as it may have possible implications for government policy. It is noteworthy that those consuming alcohol during pregnancy were only consuming a light level of alcohol (Ford, 2008). After consultation with the Scottish Government (co-funders of this research) it was decided that the sites of Edinburgh and Inverness would be chosen, to give an urban and rural examination to this research.

#### **2.7.1. Confusion surrounding advice on alcohol consumption**

It is clear that there is much confusion surrounding the advice given to women on alcohol consumption during pregnancy. Within the USA, alcohol consumption during pregnancy and FAS has been a large issue and an important health concern. Autti-Ramo (2002) identifies that one-third of obstetricians, paediatricians, and general practitioners believe that FAS could result from consumption of as little as one drink a day during pregnancy. There is still no clear limit or agreement among professionals upon a 'safe level'. Some women may justify their alcohol consumption during pregnancy as they were following previous advice given to women or lay knowledge given through other's experiences as women are likely to refer to a large range of sources in their decision-making process. Pregnant women may receive information from a variety of sources including news reports, magazines and advice from health professionals, peers, family, or friends (Raymond et al., 2009). Consequently, women are likely to come across a range of messages about alcohol consumption during pregnancy. Raymond et al. (2009) also conclude that such inconsistent reporting of information may lead to considerable uncertainty and anxiety for these women and interrupt their decision-making process. Debates around alcohol consumption during pregnancy are linked to those of abortion (Armstrong and Abel, 2000), with concern that the recommendation for abstinence may lead to women pursuing abortions (Koren et al., 2003, Koren, 1991, Koren et

al., 1996). In fact Jones and Smith (1975) suggested that early termination should be considered for severely alcoholic women. Roberts et al. (2012) found that 5 percent of women interviewed listed alcohol, tobacco or drug use as a reason for abortion, yet highlighted that women using low levels of alcohol or drugs were not terminating unwanted pregnancies because of the abstinence recommendation.

### ***Alcohol - a sensitive topic?***

The social construction of alcohol has led to alcohol being perceived as a sensitive topic. In the UK, alcohol recommendations around alcohol consumption during pregnancy are made as guidelines and are therefore not mandatory to follow. The social norms around alcohol consumption in Scotland have led to moral judgments being made about the alcohol consumption of others. As previously identified societal norms around alcohol in Scotland are linked to heavy episodic binge drinking, alcohol related violence and personal injury, and there is therefore a lot of social stigma attached to alcohol consumption, thus making it a sensitive topic for research. All studies looking at alcohol consumption within qualitative inquiry face the same issues. As with any self-reported behaviour, alcohol consumption is consistently under-reported, both because of the social stigma attached to alcohol, but also because of a lack of interpretation of what a unit is, poor recollection, estimation and the reluctance of the participant to be defined or identified as an alcoholic or as having problems with alcohol (Boniface and Shelton, 2013, Bellis et al., 2009, Marcellus, 2007, Morleo et al., 2011). People's experiences of alcohol are also highly personal and related to individual tolerance, weight and height and this therefore makes people's experiences of alcohol highly individualized and subjective.

Seppä (2006) argues that women often underestimate how much alcohol they drink and it is therefore difficult to obtain accurate drinking histories from women. In addition Barrison and Wright (1984) add that this is especially true for alcohol consumption during pregnancy. There is a tendency for women to report lower averages of consumption than are present, and Church and Abel (1998, p.198) also argues that the 'tendency to lie about drinking increases proportionately to amount of drinking'. Holloway et al. (2008, p.537) also argue that 'people do not always do what they say they do' and often under-report their alcohol consumption. It is

thought that under-reporting can be due to miss-clarification, problems with recall and underestimating because of the social desirability bias (Marchetta et al., 2012). The discussion of pregnancy and alcohol has therefore become a sensitive topic (Plant, 1986).

## **2.8. FOETAL ALCOHOL SYNDROME (FAS)**

### **2.8.1. Symptoms of FAS**

Lemoine et al. (1986) described common problems in over 100 offspring of women in France who drank heavily during pregnancy; however the term FAS was not introduced until 1973 by Jones and Smith (1973) who used the term to describe the characteristic abnormalities of children born to chronically alcoholic mothers. Murray-Lyon (1985) describe FAS as a pattern of malformations found within children of alcoholic mothers. Barrison et al. (1985, p.11) describe FAS as a 'spectrum of abnormalities in the developing foetus'. Ethen et al. (2009) established that FAS is characterised by a specific pattern of abnormal facial features, growth retardation, and central nervous system anomalies which may result in behavioural and/or cognitive disabilities. These facial features are distinctive, consisting of short palepebral fissures, flat midface, an indistinct philtrum, thinned vermilion of the upper lip and a short, upturned nose (Murray-Lyon, 1985). Poskitt (1984) argues that not all affected children exhibit all of these facial features, making the diagnosis of FAS difficult and highly subjective to the physician, FAS is often defined through these distinct facial features, abnormal growth patterns and brain damage to children. Calhoun and Warren (2007) argue that FAS is thought to be the most severe manifestation of the adverse effects of alcohol on foetal development and from examining the literature upon FAS, it is appears evident that FAS exists only within mothers who had a high alcohol intake during their pregnancy.

In his study Beattie (1986) suggested that there are indications that children with FAS suffer respiratory distress at birth. Additionally, it has been argued that alcohol consumption can also influence birth weight and the amount of weight gain that occurs within the early years of life of a child (Kenna et al., 2012, Elliott et al., 2008, May et al., 2006, 2005, 2008, Schneider et al., 2007, Poskitt, 1984). However the connection between low birth weight and FAS is contested, as levels are different across different studies on the syndrome (May et al., 2006, Barrison et al., 1985,

Barrison and Wright, 1984). Beattie (1986) underlines that because children with FAS are predominantly the offspring of chronic alcoholic mothers, some physicians have noted that, when born, children are alcohol dependent and in a withdrawal state. Additionally Poskitt (1984) adds that consequently after birth they may display symptoms such as restlessness, agitation, and convulsions. Beattie (1986) also identified that infants with FAS, developed tremors, irritability, tachypnoea and hypertonia after birth. Additionally there was excessive crying and even seizures (Beattie, 1986). Plant (1984) states that there are serious risks of spontaneous abortion amongst mothers who consumed the equivalent of 3 units of alcohol on at least 2 occasions a week during pregnancy. Poskitt (1984) argues that children with FAS may have an increased susceptibility to infection after birth which can therefore impact upon the long-term health of the child, additionally stating that FAS may only indicate a small proportion of the total damage inflicted on the foetus. Barrison et al. (1985) also argue that the effects of alcohol on the foetus may often remain undetected.

What is evident from the literature around FAS is that it is not a straightforward term. Instead it is a complex syndrome which is difficult to define due to the intricacy of the symptoms involved with a variation in diagnostic criteria (British Medical Association, 2007). Church and Abel (1998) considered that FAS is a subtle and relatively uncommon disorder that makes the diagnosis very difficult. Clear-cut diagnosis of the syndrome is, therefore, very difficult (Burd et al., 2003) and the prevalence of FAS is greatly contested because of this. It is arguable that one of the reasons that FAS is hard to define is that some of the abnormalities listed in the criteria for FAS are not specific to it and can, therefore, be found in children who do not exhibit FAS (Autti-Ramo, 2002). Autti-Ramo (2002) argues there is also no 'typical' FAS as all children are individually affected by the syndrome as there is what Barrison et al. (1985, p.12) define as 'considerable individual variation' across its range of malformations, growth retardation and abnormalities.

The detection of FAS is highly dependent upon the willingness and ability of a doctor to identify the syndrome. Chambers et al. (2006) stressed that this may have led to under-reporting of the syndrome and could be an explanation for the differing rates of FAS found. It is important to understand that the diagnosis of FAS is variable and in essence it is found where it is looked for. Recently those considered

to be experts on FAS have expanded, termed 'expertise expansion' by (Armstrong and Abel, 2000, p.278). Poskitt (1984) argues that because of this, the condition is consequently being recognised more frequently as clinicians become more aware of the syndrome. However, it is important to remember the argument (Armstrong and Abel, 2000) that FAS still remains a rare outcome of maternal alcoholism during pregnancy. Armstrong and Abel (2000) argue that global levels of FAS have been exaggerated by media reports.

Edwards and Werler (2006) purport that alcohol may influence hormone levels and consequently may disrupt a woman's reproductive cycle. The consumption of alcohol may, therefore, even impair a woman's recognition of pregnancy. Waterson and Murray-Lyon (1989) argue that drinking patterns prior to conformation of pregnancy can also impact upon foetal growth and Barrison et al. (1985) conclude that heavy drinking before pregnancy may be detrimental despite reduction during pregnancy. Ethen et al. (2009) purport that a high level of consumption of alcohol before pregnancy is indicative of moderate levels of alcohol use during pregnancy. This is supported by Poskitt (1984) who argues that some of the effects of chronic drinking may continue to influence foetal growth and development beyond the duration of alcohol ingestion.

### **2.8.2. Other conditions associated with alcohol consumption during pregnancy**

Other related neuro-developmental disorders, involving neurological abnormalities are argued to be associated with alcohol use during pregnancy. Connolly-Ahern and Broadway (2008) state that alcohol-related birth defects (ARBD) including skeletal and organ deformities and Foetal Alcohol Spectrum Disorder (FASD) also exists. FASD is an umbrella term that covers a range of conditions that can occur. Its effects may include physical, mental, behavioural, and/or learning disabilities which all might have possible lifelong implications (Connolly-Ahern and Broadway, 2008). Foetal Alcohol Effects (FAE) are also recognised (Barrison et al., 1985, Poskitt, 1984) consisting of less extreme effects than FAS. Alcohol Related Neurodevelopmental Disorder (ARND) also has been identified (Autti-Ramo, 2002). Chen (2012) links prenatal alcohol consumption with various behavioural problems in children, suggesting that the consumption of alcohol during pregnancy leads to increasing infant difficultness, and that children are vulnerable at light to moderate

levels of drinking. However, it could be suggested that these further abnormalities could be another way of stigmatising pregnant women.

### **2.8.3. FAS and Health Inequalities**

The links between alcohol and inequalities in health are well documented. There is a strong link between poverty and ill health and between increased alcohol consumption and poverty. Many women within Britain consume alcohol above the recommended allowance, and there is a popular contention that the poor are heavy drinkers (Marmot, 1997). Yet the problems from alcohol consumption are not confined to the relatively small amount of the population who are heavy drinkers. Marmot (1997) contends the type of alcohol consumed may also vary with social class and the consumption of alcohol is directly related to the price of it. This has a dramatic effect when examining its role in inequalities of health.

It is evident from the literature surrounding FAS that the disorder is strongly linked to poverty (Abel, 1998b, Armstrong and Abel, 2000). This therefore suggests that the causal link is about overall life chances, lifestyles and behavioural choices. Waterson and Murray-Lyon (1989) also infer that there is a link between poverty and the development of FAS, and Abel (1998b) concurs, indicating that FAS may be a consequence of a combination of alcohol abuse and poverty as the Social Economic Status (SES) of an individual is a factor contributing to FAS. Income is therefore thought to be a highly important factor within the incidence of FAS; consequently women of a lower social class and a lower income are at more risk of having a diagnosis of a child with FAS. Barrison et al. (1985) argue that FAS is found in socially marginal groups prone to high alcohol intake. This connection is also identified by Chambers et al. (2006). From an Australian perspective, Mutch et al. (2009, p.80) contend that ‘populations most at risk for FASD are those with a high degree of social deprivation and poverty; however, FASD occurs throughout society’. Plant (1986) argues that there are many factors than can influence pregnancy outcome that also need to be considered, such as the use of tobacco and other drugs, plus general health, diet and social class. Poskitt (1984) argues that this link may be because areas with low social economic status have a lifestyle that is accepting of regular drinking, and therefore women may be at a greater risk of having a child with FAS. The links between chronic alcoholism and poor diet are



important variables in the development of FAS. It is important to note that this link is not between women who occasionally drink, despite the evidence that there is no 'safe' level of alcohol consumption during pregnancy. We are concerned here with the link between alcohol dependent women and the prevalence of FAS. There are other behavioural aspects that are important here but, poverty exacerbates it. Women may also be unemployed and therefore of a lower socio-economic status, as a consequence of their drinking (Marmot, 1997). In Canada, FASD is often framed in colonial ways marginalising the needs of women (Hunting and Browne, 2012, Salmon, 2004, 2010). Certain populations of women have been examined especially such as the prevalence of FAS amongst offenders in the USA (Sung, 2012).

Research has however indicated that women of a higher social class are likely to consume alcohol during pregnancy as revealed in an analysis of GUS data (Ford, 2008). This is in agreement with Edwards and Werler (2006) who in their findings indicate that women who drank during pregnancy were likely to have some level of college education, a household income of more than \$35,000 per year and to have had no previous pregnancies. This finding is also similar to the work of Ethen et al. (2009) who argue that alcohol consumption during pregnancy increased with age, education and income. It is clear therefore that there is a tendency for high levels of alcohol consumption during pregnancy amongst women with a high social class and income. It is clear that despite the evidence that shows women of a high income and class consume alcohol during pregnancy, FAS is still a low class syndrome and is associated with poverty. Because of its associations with poverty and low social economic status, Armstrong and Abel (2000) argue that FAS is inseparable from poverty and smoking. However, FAS must be regarded within the alcohol context instead of merely the context of poverty (Armstrong and Abel, 2000) and there are recognitions that poverty makes things more difficult to accomplish. 'Poor women face the same dilemmas in defining themselves as good mothers' (McCormack, 2005, p.666).

#### **2.8.4. Prevalence of FAS**

There is considerable contestation surrounding the existing global levels of FAS. Rates of FAS are claimed to differ dramatically between countries and the majority of epidemiological surveys upon FAS are from the USA where there is a great

awareness of FAS. The majority of evidence into women's alcohol consumption during pregnancy is American, as there has been concern within the USA regarding FAS and as a consequence higher levels of FAS have been reported in the USA, probably due to a greater monitoring for FAS within America. Barrison et al. (1985) argue that the adverse effects of alcohol are clearly 'preventable'. This gives an indication of the concept of surveillance/power in the manipulation of pregnant women in regards to the consumption of alcohol during pregnancy. There are cultural differences between the way in which abstinence from alcohol is recommended between the USA and the UK (Campbell and Ettorre, 2011). Poskitt (1984) considered that it is impossible to estimate the prevalence of children damaged by maternal drinking. This therefore has an effect upon the apparent prevalence of FAS. Barrison and Wright (1984) estimated that FAS has a worldwide prevalence of between 1 in 600 to 1 in 1000 live births whereas Abel (1988) identified the global rate to be 1.9 per 1000 births. Ethen et al. (2009) found that FAS existed within 0.5 to 3 children per 1,000 live births in the US. Abel (1998a) identified that 91 out of 95 observations of FAS were diagnosed in the USA, illustrating how FAS is readily identified within America, and identifies a worldwide incidence of 0.97 cases per 1000. It is important to note that Abel (1998b) recognizes that this worldwide estimate is based almost entirely on prevalence within the USA. The Centres for Disease Control and Prevention (CDC) place the incidence of FAS in the US general population at less than 0.67 per 1000 (Centers For Disease Control and Prevention, 1997). Campbell and Ettorre (2011) examine how the moral values are so embedded in this discourse in the USA. Abel (1998a) however, recognises that the prevalence of FAS increases to 4% when focussed on women who are selected on the basis of their heavy drinking during pregnancy.

Autti-Ramo (2002) documents that within Finland 9.1 per 1000 live births involve children affected by the FAS, FAE or ARND. It is important to note that this rate is of live births and maternal alcoholism is correlated with increased rates of stillbirth. May et al. (2006) suggested that the rate of FAS in the Lazio region of Italy is 3.7-7.4 per 1,000 children and total FASD (Foetal Alcohol Spectrum Disorder) is in the order of 20.3-40.5 per 1,000. In their study in France, Malet et al. (2006) identify 2 cases of FAS out of a population of 1,035, therefore identifying a level of FAS less than the levels previously suggested. One issue is that FAS only represents 'one

focus of a continuum of disturbed foetal development following prenatal exposure to heavy amounts of alcohol' (Autti-Ramo, 2002, p.98). Poskitt (1984) state that the incidence of FAE is more common than FAS, because it is an all-inclusive term. It can be seen from these citations that the prevalence of FAS, however, is not always accurately reported or estimated and Mutch et al. (2009) argue that FAS is almost certainly under-diagnosed. The implication is that the rates of FAS are probably higher than previously thought. FAS is increasingly becoming viewed as a problem which many countries such as South Africa now seek to prevent by considering legislation to limit the sale of alcohol to pregnant women (Child, 2012, Laing, 2012).

### ***Prevalence of FAS in the United Kingdom and Scotland***

Murray-Lyon (1985) argue that FAS has both a variable and an unpredicted incidence, Beattie et al. (1983) identified forty cases of FAS in the west of Scotland, and suggested that FAS is reported to occur in approximately 10% of live births from pregnancies where there were levels of chronic heavy drinking (Beattie, 1986). However these estimates are out of date as drinking patterns have changed in Scotland since the 1980s and a major study into FAS has not been carried out there since 1986. There has been no recent prevalence study, but the Scottish Government have carried out an assessment into the scope of conducting one, by holding stakeholder meetings (The Scottish Government, 2009).

Caan (2012) purports that alcohol related disabilities affect roughly 1% of children in the UK. Poskitt (1984) identified a rate for the United Kingdom of 1 or 2 cases per 1000 births. Within Liverpool in England, FAS is identified to occur in more than 1 in 2500 births. Beattie (1986, p.165) suggests that 'full FAS' is a 'rarity' and is only identified in 'approximately 2.5% of live births after heavy drinking pregnancies'. However the results of both of these studies are probably out of date, as subsequently drinking patterns within the UK have altered.

Alcohol problems across women are increasing (Thom, 1997a). There is a growing rate of alcohol related ill-health in Scotland but the prevalence of FAS is unclear. There has been coverage of FAS within the Scottish media, with reports suggesting that within Scotland as many as 300 babies a year are damaged by alcohol consumption during pregnancy (Scotsman, 2007a). The difficulties in diagnosing the syndrome may impact upon the level of FAS observed in Scotland as noted

previously. Scottish estimates based on estimates from other European countries suggested that 37 babies a year are born with FAS in Scotland and that as many as 340 babies are being born with FASD (Scotsman, 2007a). Other figures in the media have indicated that up to 1 in 10 and as many as 9,000 babies could be suffering from FASD in Scotland (Foster, 2007), yet no accurate statistics currently exist for the numbers of children with FASD in the UK and estimates are often taken from FAS pressure groups such as The National Organisation On Foetal Alcohol Syndrome (NOFAS) (Lowe et al., 2010). Despite the media reports on FAS, it remains unclear how many cases of FAS really exist within the country. Within Scotland there is anxiety over women's alcohol consumption in pregnancy, and there is interest in tackling the health and social problems of alcohol consumption. It is recognised that there is difficulty in accurately defining and identifying FAS because of the varied symptoms and forms that the syndrome takes.

Across the literature on alcohol consumption during pregnancy, the definitions used for alcohol abuse, alcoholism, alcohol problems, light moderate or heavy consumption differ. There is no general consensus as to what constitutes heavy drinking. This creates problems when examining publications and comparing studies and results and when trying to determine if a 'safe' level of alcohol consumption during pregnancy exists. The levels of drinking that constitute 'heavy' drinking differ greatly within epidemiological studies on Foetal Alcohol Syndrome (FAS) which is claimed to be the most serious manifestation of drinking in pregnancy. This has complications when trying to conclude that heavy drinking during pregnancy is detrimental to foetal health.

## **2.9. DEFINITIONS OF ALCOHOL UNITS AND LEVEL OF DRINKING**

The purported risks of alcohol consumption during pregnancy are well documented; however they are still widely disputed. It has been thought that although the placenta acts to bring nutrients to the developing foetus and confers some protection, it does not act as a protective barrier to the widespread distribution of alcohol taken by mothers. Beattie (1986) suggests that foetal and maternal blood alcohol concentrations are virtually identical. As argued:

Exposure to the foetus of alcohol may carry a wide range of consequences for foetal health, including an increased risk of respiratory

distress syndrome at birth, increased risk of premature birth, and central nervous system defects. The most serious manifestation is Foetal Alcohol Syndrome (FAS)

(Malet et al., 2006, p.787)

Although there are links between heavy alcohol consumption and risk to the foetus, the risk of low to moderate alcohol consumption during pregnancy still remain uncertain with many studies reporting conflicting results. Parackal et al. (2009) recognise there is a lack of certainty if any level of alcohol consumption is safe.

Definitions on light drinking differ between studies, for example in the examination of the research literature on the results of drinking during pregnancy, Knupfer (1991) defines light drinking as no more than 2 drinks per day, which may be repeated between 4 and 6 times a week. Contrastingly, in their analysis of newspaper coverage of FASD, Connolly-Ahern and Broadway (2008) noted that across studies the definition for light drinking varied between ‘one sip’ of alcohol to fewer than five drinks per week. Definitions of heavy drinking differ between studies, Waterson and Murray-Lyon (1989) define as the consumption in excess of 56 units of alcohol per week, yet Church and Abel (1998) considered heavy drinking to be the consumption of an average of more than 2 drinks a day or 45 drinks or more per month. There is much contestation in what defines heavy levels of alcohol consumption. Heavy alcohol consumption, of more than 80g of alcohol per day is seen by Murray-Lyon (1985) to cause FAS within the UK. Chambers et al. (2006) argue that adverse problems are associated with even moderate levels of alcohol consumption in pregnancy, yet the definition of ‘moderate’ is unclear and greatly differs between studies.

The methods of classifying drinkers are questionable. The use of an average to evaluate drinking consumption is also problematic as there is no realistic description of a drinking pattern or of the volume consumed, given that different drinks are of different strengths and sizes (Knupfer, 1991). There is also a recognised problem in the use of a unit for measurement as drinkers have difficulty defining and pouring standard drinks (Kerr and Stockwell, 2012). Instead of using an average as a unit of analysis, Knupfer (1991) argues that the number of drinks should be the unit of analysis as that number is easy to understand. However, Abel (1998b) recognises

that there is difficulty in comparing ‘drinks’ as a ‘drink’ is not a standardised amount of alcohol. Knupfer (1991) also contends that the use the term ‘or more’ within definitions, is also problematic as it may include a large range and is therefore not specific enough. Armstrong and Abel (2000) also draw attention to the unreliability of the method of averaging as it obscures the true level of alcohol consumed. Therefore there are disparities across different studies between the unit of analysis. This lack of consistency makes findings harder to compare between studies and consequently makes the identification of a suitable recommendation during pregnancy more difficult. Thus, as Murray-Lyon (1985) argue, no certain data exist on what a safe lower limit for drinking in pregnancy can be identified. The work of Ettorre (2007) however argues that the quest for a ‘safe’ level for alcohol consumption, is another example of the way in which control over women during pregnancy is sought.

## **2.10. AGREEMENT OF HARM FROM BINGE/HEAVY DRINKING**

As previously argued it is unclear what level of alcohol consumption is ‘safe’ during pregnancy; however there is general agreement that large amounts of drinking or episodic drinking are harmful to the health of the unborn child. May et al. (2005) argue that women who drink heavily are at a high risk of having a child with FAS. No level of alcohol consumption during pregnancy has been shown to be safe, however some studies have found that binge drinking is particularly dangerous because it exposes the foetus to a high blood alcohol concentration (Ethen et al., 2009) yet Kesmodel et al. (2012) found no association between binge drinking during early pregnancy and child intelligence. There is therefore an inherent problem in identifying the causal affect of prenatal alcohol exposure (Chen, 2012).

From studying heavy drinking amongst pregnant women in the Scottish Highlands, Beattie (1986) expounded that chronic heavy drinking may be detrimental to the foetus. Binge drinking is harmful but its role within FAS and pregnancy is contested. Autti-Ramo (2002) considers that when a similar volume of alcohol is consumed, binge drinking is more harmful than when the same amount of alcohol is drunk over a longer period. Furthermore, evidence suggests that ‘heavier, episodic, or ‘binge’ drinking is the specific pattern of pregnancy drinking that confers the highest risk of FASD’ (Chambers et al., 2006, p.133). However some academics argue that there is

no evidence that binge drinking causes FAS (Barrison et al., 1985, Murray-Lyon, 1985). Barrison and Wright (1984) opined that many women are potentially putting their infants at considerable risk by continuing to drink large amounts of alcohol whilst pregnant.

There seems to be little research conducted into the effects of alcohol consumption whilst breastfeeding. Although alcohol consumption during breastfeeding would not cause FAS it is recognised that it may cause negative affects to the health of the child. Giglia and Binns (2007) argue that information regarding safe levels of alcohol consumption during breastfeeding is limited. Yet, there is a wealth of information regarding women's alcohol consumption during pregnancy. Contrasting views therefore have emerged on what messages women should be given regarding the consumption of alcohol during pregnancy and how this message should be delivered (Campbell and Ettorre, 2011). Abel (1998b) argues that the general stress during pregnancy combined with the belief that they have harmed their unborn child may paradoxically be harmful to that child and that a woman who is a 'light' drinker may feel needlessly guilty about that single drink she consumed once a week during her pregnancy.

Abel (1999b, p.4) argues that since the term FAS, by definition, only occurs among women who are 'alcoholics', the term trivialises the real impact of alcoholism during pregnancy by implying that any amount of 'alcohol' rather than 'alcoholism' is causative'. Consequently Abel (1998b) suggested that FAS should be renamed Fetal Alcohol Abuse Syndrome (FAAS) and Alcohol-abuse-related Birth Effects (AARBES). The authors therefore argue that the emphasis of the risk of FAS should be at alcoholic women, as it is only the heavy consumption of alcohol during pregnancy which is correlated with harm. The female pregnant drug using body is perceived as a polluted foetal container (Murphy and Rosenbaum, 1994), Ettorre and Kingdon (2010) also find women who drink to be stigmatised as doubly polluted, their bodies as well as their foetuses.

Some proponents of the risks of FAS argue that there is no benefit of foetal exposure to alcohol, as Autti-Ramo (2002) consider: no child should be born with damage resulting from exposure to maternally consumed alcohol simply because of ignorance. It is evident that no 'safe' level exists, of alcohol during pregnancy, as it

is hard to locate alcohol as the only source of harm. Both Knupfer (1991) and Plant (1984) argue that there is no or little evidence that light drinking is harmful to foetal health and Plant (1984) further commented that as there is little evidence that light drinking is harmful to foetal health although there is agreement that heavy consumption causes, as yet there is little consensus on the levels or patterns of alcohol consumption at which harm actually occurs. Knupfer (1991) postulates that there is no evidence that light drinking is harmful to the foetus, and it is argued that:

A strong popular, even dogmatic, movement today in the health promotion field: that attempts to convince ('educate') pregnant women that if they drink any alcohol during (and for some time before) pregnancy they are endangering their child and risking that it will be born with some abnormality. There thus develops the premise that that any amount of drinking in pregnancy poses a threat to the foetus

(Armstrong and Abel, 2000, p.277)

There is thus difficulty in demonstrating any adverse effects of light drinking (Knupfer, 1991). Indeed light drinking is the norm for some contexts, consequently Knupfer (1991, p.1072) argues that 'should this pattern of drinking cause foetal damage, entire populations would be affected'. Church and Abel (1998) also concludes that there is an overwhelming number of women who drink during pregnancy and who have never experienced any problems as a result of their drinking. Knupfer (1991) points out that light drinking has not been well enough defined in this body of research and that such a serious omission should be considered in the context of a fairly strong popular anti-alcohol tide. It is apparent that the confusion surrounding the advice given to women and what counts as a drink has led to women being pressurised into not drinking any alcohol. Stockwell et al. (2012) argue that there is no consistent damage found across studies at lower levels of alcohol consumption and that low-to-moderate drinking did not present an increased risk. Further recent studies have also concluded that children whose mothers drank to a light level during pregnancy faced no increased risk of clinically relevant behavioural difficulties or cognitive deficits compared with children of abstinent mothers (Kelly et al., 2009, Kelly et al., 2010).



## **2.11. MESSAGES ABOUT ALCOHOL IN PREGNANCY: CONTROL OR SCAREMONGERING**

It has been argued that FAS is entirely preventable, as the syndrome stems from a modifiable behaviour. Thus in order to eliminate it, Abel (1998b) argues that there is a need to increase awareness among general public of FAS. Abel (1999a) declares that to prevent FAS, those women who are truly at risk must be identified and targeted for preventive efforts. Within America there is a growing movement to prevent FAS, but this movement is also thought to be attempting to control women's bodies (Campbell and Ettorre, 2011). Ethen et al. (2009) indicates that methods are needed to prevent alcoholism during pregnancy, and drinking prior to pregnancy, whilst Poskitt (1984) considers that it would be wise to caution all women of childbearing age to have no more than one drink a day.

However the process of warning women against alcohol consumption and the change in guidance has left many women feeling confused regarding a safe limit. Abel (1998b) argues that this implication that any amount of alcohol is harmful has led to people wanting to terminate their pregnancies to prevent the possibility of giving birth to a child with a birth defect. Armstrong and Abel (2000, p.278) state that this movement for prevention of FAS is therefore 'urging alcoholics to abort' any child that may have been harmed due to alcohol consumption. Within America there has been a movement to encourage women to stop drinking during pregnancy altogether (Campbell and Ettorre, 2011). This movement has taken many forms of advertising and education to the prosecution of women (Oaks, 2001, Daniels, 1993, Roth, 2000).

### **2.11.1. Legal sanctions**

Powerful moral and legal sanctions exist, in many societies, for those women who are regarded as not preparing appropriately to become a mother, are acting irresponsibly, or are placing the life of the foetus at risk (Miller, 2005, Murphy and Rosenbaum, 1994). As previously argued questions exist over the rights of pregnant women versus the rights of their foetuses (Handwerker, 1994). It is already evident that the USA has developed, or is in the process of producing, a legal and medical system that monitors pregnant women. Such systems will control women and keep them in line with legal statutes that encompass the abuse of the foetus (Rothman, 2000). These, therefore, engage with the idea that the mother herself can pose harm

to the foetus. The causes of foetal damage are thus recognised as being caused by 'bad mothers or inept workers' (Rothman, 2000, p.6).

From the above discussions it is clear that both drug use and alcohol consumption during pregnancy are highly stigmatised and may even be legally punishable. Women in the USA have been imprisoned for child neglect for the consumption of alcohol whilst pregnant. These legal cases reflect a view which gives the foetus more rights than the mother. As Campbell (1999) argues these legal sanctions reveal how the state is constructed to exercise power over its citizens. Handwerker (1994) argues that consequently this fails to understand that pregnant women make decisions based on the contexts of their lives and decisions that are constrained by and that fall within their social world.

Pregnant bodies are targeted through the 'moral panic', which has arisen over the maternal alcohol consumption and they face a punishment through 'scapegoating' policies (Ettorre, 2007, p.98). As discussed earlier, there is little evidence to show that drinking affects the foetus, apart from when done so in a heavy capacity. Therefore many women may be punished for behaviour that potentially has no effect of the newborn. Deville and Kopelman (1998) questioned the context by which society punishes its individuals criminally with potential imprisonment merely for creating a risk of harm. This policing of pregnant women's lifestyle choices and surveillance of pregnant bodies highlights the cultural imperative impelling women to produce within the 'regulatory regime of reproduction' (Ettorre, 2007, p.100).

Connolly-Ahern and Broadway (2008) argue that the increasing coverage given to this matter may provoke 'child-victim' coverage. As noted by Connolly-Ahern and Broadway (2008) and Armstrong and Abel (2000) women have been charged with criminally abusing their foetuses for consuming alcohol whilst pregnant. In 1990 Wyoming also became the first state to charge a pregnant woman who was drunk with felony child abuse. Armstrong and Abel (2000) also give examples of where 'morally righteous' waiters and bar staff have refused to serve pregnant women with alcohol. Upton and Han (2003) conclude therefore that women are becoming increasingly subject to heightened social control. Reports also exist of visibly pregnant women being harassed by indignant strangers when seen to be drinking in public (Armstrong and Abel, 2000). Within the USA there is a large regulation of

women and their bodies. This policing of pregnant women has led to women feeling discriminated against for being pregnant. The moral panic surrounding alcohol consumption in pregnancy has contributed to the regulation of the body.

It is also argued that checking fetuses for various ailments is a form of regulation by doctors, as the 'testing of fetuses – serves the function of 'quality control' on the assembly line of the products of conception, separating out the products we wish to develop from those that we wish to discontinue' (Rothman, 2000, p.6). The regulation of women's bodies by medical 'experts' is therefore important in producing discourses of motherhood. However, it has been identified that this is not always restricting, as women can challenge the power held by doctors. It is contested over what rights a mother should hold over her body whilst pregnant in respect to the fetus.

Hunting and Browne (2012) argue that the discourses around FAS/FASFD construct mothers as dangerous for drinking during pregnancy and assumes the fetus is at risk; this draws upon the maternal responsibility of the mother, which reveals preventing harm as an individual choice of women. Similarly in their study into the coverage of FASD in regional newspapers in the US, Connolly-Ahern and Broadway (2008) found that coverage focussed upon the themes of 'dangerous mothers', 'fetal wellness' and 'victimization'. The principle of moral equality, at the heart of public health, sees the health of individuals as even presenting the idea that no individual is worth more than another (Graham, 2010). This however is contrasted through the idea that the mother is merely a container for foetal health, and that the health of the fetus is more important than the health of the mother. This 'moralization' (Hier, 2008) or 'moralising medical model' as purported by Hunting and Browne (2012) sees women's education as a solution to the constructed social problem of women's alcohol consumption during pregnancy. Bazzo et al. (2012) contend that public health messages provoking fear produce the greatest behavioural change. In their work the image of a fetus inside a glass of alcohol obtained a high level of visibility and was effective in spreading the message it portrayed, however the picture was viewed as strong and shocking by the mass media.

The large media attention focussed upon FAS has meant that many people now have a vast knowledge of the harm that alcohol consumption during pregnancy can cause.

However it is argued that this is a means of scaremongering and a form of control over women's bodies (Geddes, 2012, Mosley, 2013). As there is an unclear safe level of alcohol consumption, some writers argue that it would appear wise to advise women to avoid the consumption of alcohol during pregnancy. Within the UK there has been a large amount of media attention focussed upon the change in recommendation by the Department of Health on alcohol consumption during pregnancy (Geddes, 2013, Ettorre, 2007, The Scottish Government, 2007, Barnes, 2012, Bennett, 2007, Child, 2012, Foster, 2007, Hope, 2007, Laurence, 2008, Martin, 2007, Moran, 2007, Mosley, 2013, O'Reilly, 2010, Parry, 2007, Rose, 2007, Scotsman, 2007a, 2008a, 2008c). There is a growing concern over what pregnant women should do and whether the new guidelines are needed (Breeze, 1985b, 1985a). Many women feel confused and stressed regarding their alcohol consumption, in some cases this stress is even triggering alcohol consumption with, it has been estimated, one in every 25 women turning to alcohol (Bee, 2007). Other current attitudes seem to view the new guidelines as 'melodramatic' (Moran, 2007) and that women should be allowed to come to a decision for themselves (Bennett, 2007).

### **2.11.2. Critique of messages around abstinence and FAS**

Critiques of FAS have highlighted how messages given to women still remain unclear. Women's alcohol consumption has been linked to syndromes such as FAS, and women are now being told to not consume alcohol during pregnancy. However, this is an unclear message, as pregnant women are not made aware that FAS is linked 'more to the actual amount of alcohol a woman drinks than to alcohol itself' consequently, 'Do not drink during pregnancy appears to be based on unequivocal, scientific fact – which in fact it isn't' (Ettorre, 1997, p.107). This suggests that FAS may be as much about increasing medical control over women's bodies during pregnancy as the prevention of foetal harm. Armstrong and Abel (2000, p.279) argue that 'The National Organisation on Foetal Alcohol Syndrome (NOFAS) continue to espouse the view that FAS is a threat to all pregnancies' contributing to the creation of a moral panic over FAS. This view is also adopted by Barker and Hunt (2004) who are also critical of abstinence policy, arguing that the message is being aimed at too wide an audience, as most alcohol consumers are not dependent drinkers.

Ettorre (1997) further contends that it is important therefore that women are given a choice and are informed of the risks of heavy drinking during pregnancy and the effects that this can have on foetal health rather than being told to abstain completely. This information should be based on clear scientific evidence and not moral judgements. It is more ethical to communicate the inconclusive nature of the scientific evidence to women with an accurate assessment of the risks as messages which women do not trust may lead to women ignoring the advice, and ignoring the advice on other health matters also (Leppo and Hecksher, 2011, Gavaghan, 2009). The challenge, therefore, is to formulate advice that delivers a clear, definitive message whilst the risks of drinking still remain uncertain (Leppo and Hecksher, 2011). Gavaghan (2009, p.303) argues the message of abstinence can be perceived to be 'patronising and paternalistic' and Ettorre (1997) emphasises that that women must not be kept in a state of ignorance over the effects of alcohol:

For example, there is a big difference between telling a pregnant woman to stop drinking totally because one sees it as morally reprehensible and telling a woman to stop drinking heavily because it is a proven medical fact that heavy drinking during pregnancy may be physically harmful to her and the foetus

Ettorre (1997, p.108)

The knowledge gap of uncertainty over the effect of low levels of alcohol consumption during pregnancy on the foetus complicates the formulation of policy and recommendations to pregnant women (Leppo and Hecksher, 2011, Gray et al., 2009, Kelly et al., 2009, Henderson et al., 2007a, Abel, 2009). There is a plethora of confusing and contradictory information available on FAS and the effects of maternal alcohol consumption during pregnancy, which Ettorre (1997, p.109) describes as 'a 'dangerous social cocktail' because it acts as a poison which kills a woman's right to take responsibility for her body and drinking during pregnancy. Women need to know that 'their well-being and that of their future children is in their own hands' (Ettorre, 1997, p.109).

### **2.11.3. Increased attention of FAS and the response to FAS in the UK and Scotland**

Connolly-Ahern and Broadway (2008) postulated that FAS is a 'big' problem and 'foetal abuse' is a growing cause of social concern. This view is evident from the reaction to women who consume alcohol during pregnancy, especially in the US where increases in levels of FAS are associated with a 'perceived increase in child abuse and neglect' (Armstrong and Abel, 2000, p.276). However these increases could also be due to increased recognition of the syndrome. Leppo and Hecksher (2011, p.7) argue that the change towards an adoption of a total abstinence model in Finland and Denmark 'is closely linked to a change in the social and cultural climate regarding FASD' and it could be argued that the same is taking place within Scotland. This has been linked to wider international trends following an increased interest to FAS in America, Africa and Australia. Leppo and Hecksher (2011) argue that this is a societal urge, or a moral panic, to prevent FAS. There is therefore a growing critique of alcohol and pregnancy and the overconsumption of alcohol by women.

The marked trend in increase of women's alcohol consumption has provoked an increase in concern over women's alcohol consumption played out by the media as a case of moral panic. This has inflated fear and anxiety about FAS beyond levels warranted by the evidence of either its prevalence or impact and created what Armstrong and Abel (2000, p.278) define as exaggerated 'feverish' concerns. There has been increasing public attention paid to FAS/FASD, in Scotland, with growing discussion of the syndrome and the role of maternal alcohol consumption, both within the media and by politicians.

FAS and women's alcohol consumption during pregnancy has received large media coverage within the USA and the UK and the concept has brought birth defects to international attention (Abel, 2001a). FAS has taken on the status of a 'moral panic' and is now a 'major public health concern and a national health priority' (Armstrong and Abel, 2000, p.276). A key feature of a moral panic as defined by Cohen (2002) is the 'proliferation of concern about a certain threat which overstates the actual danger the subject of the panic possesses' (Leppo and Hecksher, 2011, p.9). This generalised social crisis sees the consumption of alcohol as a threatening behaviour

to society (Salmon, 2004) and sees FAS as a social problem. These media responses have led to a growing fear surrounding FAS. Foetal health has become an object of great interest and the growth of new medical technologies, has led to increasing recognition given to disorders such as FAS and FASD (Leppo and Hecksher, 2011, Armstrong and Abel, 2000, Drabble et al., 2011, Bell et al., 2009).

Because of the expansive media coverage of alcohol consumption during pregnancy and FAS, there is a strong vested interest in its elimination. Armstrong and Abel (2000) argue that within the USA, FAS has entered the arenas of both scientific and public awareness. FAS is a major public health concern and Malet et al. (2006) discern that efforts are needed on information and awareness-raising campaigns targeted at healthcare professionals. Some researchers such as Armstrong and Abel (2000) argue that the prevalence of FAS could be reduced using public education campaigns to alert all pregnant women to the potential dangers of drinking; however the efficiency of these campaigns is debatable. Malet et al. (2006) argue that despite public education campaigns drinking is not perceived as presenting specific dangers and some findings indicate that more women are now drinking during pregnancy (Armstrong and Abel, 2000). It is clear therefore that education campaigns have not prevented alcohol consumption in pregnancy. In the USA, Abel (1998b) identified that, irrespective of how aware Americans are of the message, any increased awareness has not resulted in long-term decreases in alcohol consumption. Prevention initiatives have been described as inconsistent (Malet et al., 2006) and public education, e.g., warning labels, has had no noticeable effect in reducing drinking during pregnancy (Armstrong and Abel, 2000). Such findings, as indicated above, emphasise that it is the individual who needs to take responsibility for the consumption of alcohol and this is linked to the turn towards individual responsibility for health care (Crawford, 1986). Unfortunately it is also unclear what can be done to prevent women from drinking during pregnancy.

Lowe et al. (2010) argue that the cultural understandings of FASD are linked to broader ideas about motherhood. Within the USA, there is a large regulation of women and their bodies. This policing of pregnant women has led to women feeling discriminated against for being pregnant as drinking is increasingly being seen as incompatible with the ideology of a 'good' mother. Hunting and Browne (2012) argue that, in discourses around the consumption of alcohol during pregnancy and

FAS/FASD, women are often framed as the problem. By labelling women as the problem the other social or structural influences, or health inequalities are ignored and women are therefore stigmatised and blamed.

The moral panic surrounding alcohol consumption in pregnancy has contributed to the regulation of the female body, with the media spin on these events of alcohol and drug use during pregnancy portraying women as a biological underclass (Paone and Alperen, 1998, Campbell and Ettorre, 2011). The length of the moral panic surrounding FAS and the consumption of alcohol during pregnancy is evident, as studies have even been carried out to evaluate the additional risk of the use of alcohol-based hand sanitizers by pregnant health care workers (Evans and Orris, 2012), despite no significant risk of the inhalation of alcohol being found. We need to therefore further understand the multiple factors which influence women's use of alcohol during pregnancy (Hunting and Browne, 2012). Mass media campaigns are commonly used to raise awareness of health messages as they reach large sections of the population and remain a major cultural forum for the circulation of understandings (Lyons et al., 2006). The intention of the campaigns is to both communicate and instil a single clear message to the public which can begin to change social norms (Cavill and Bauman, 2004, Thompson and Kumar, 2011). Those who engage in these media campaigns however rarely take what is offered to them directly, as people engage with media content, drawing on it for particular purposes, (Hodgetts and Chamberlain, 2003) therefore 'accepting, rejecting, resisting and modifying representations to suit their own particular purposes' (Lyons et al., 2006, p.224). Bunton and Crawshaw (2006) purport that the media has a role in representing and constructing the normal/healthy individual and problematic behaviours. Recently on UK Television soap, Coronation Street, a young pregnant woman was told by her partner and family that she shouldn't drink during pregnancy, after drinking alcohol she experienced stigma for putting the baby's health at risk. The programme has an average audience of 9.4 million viewers for each episode every week (ITV, 2012) and clearly provides a cultural representation of how pregnant women should act, in demonstrating the popular representations of how the body should behave during pregnancy, especially drinking during pregnancy. As Verma et al. (2007, p.575) argues 'popular television serials offer the



chance to portray “healthy” behaviours as normal, and so help change attitudes and shape behavioural norms among the viewing public’.

I would argue that the introduction of a recommendation for abstinence and the moral panic surrounding FAS has led to an increasing awareness of the perception that women should abstain from alcohol. The idea is being portrayed that mothers should take no risks with the child’s health drawing upon the ideology of motherhood and responsibility, yet as discussed previously there is still no proven risk of harm from low/moderate alcohol consumption. This increasing widespread concern and urge to protect the foetus has led to the changing social context of FAS prevention, with increasing rights being given to the foetus over the mother.

The increased attention to FAS within Scotland has in turn led to a criticism of mothering, and a general concern over women’s citizenship, with Harry Burns, Scotland’s CMO postulating that drinking during pregnancy causes FASD which in turn was directly linked to antisocial behaviour on Scotland’s streets. He quoted as stating:

I would bet the incidence is very high in young men being violent. If you can identify the risk factors in that, that is something we can definitely intervene in

(Laurence, 2008, p.1)

Golden (2000) usefully highlights the way in which there has been increasing attention paid to women’s alcohol consumption during pregnancy linked to the aforementioned concerns around citizenship and the causation of fights in Scotland to mothers who drank during pregnancy (Laurence, 2008). These contrast with the appropriate ways of mothering as proposed by Miller (2005). Armstrong and Abel (2000, p.276) even go so far as stating that FAS has led to the ‘emergence of a new social problem: the victimisation of children’ and that alcohol consumption during pregnancy can be construed as ‘child abuse to the unborn foetus’. Alcohol consumption during pregnancy is therefore associated with a concept of ‘bad’ mothering and is a form of maltreatment to the unborn child. Consuming alcohol during pregnancy has now become part of ‘the current anti-alcohol/drug crusade’ (Armstrong and Abel, 2000, p.276). Blame is no longer given to social inequality,

instead the moral panic shifts the blame for poor pregnancy outcomes to individual mothers (Armstrong and Abel, 2000).

## **2.12. CONCLUSIONS**

The literature around the consumption of alcohol during pregnancy calls for the individual management of risks and follows the medicalisation of pregnancy and ideology of motherhood highlighting a call to do pregnancy the right way. Medical discourses still expect women to be turning to the experts for advice on their pregnancies, and still put less value on to the role of lay health beliefs.

It is important that we understand and reflect on the theories around women and motherhood, in developing our understanding of women's use of alcohol during pregnancy. The ideology of the 'good' mother is important for how women understand and relate to health recommendations as the moral panic around FAS has shifted the blame on to mothers rather than social circumstances.

Public health messages in general and especially those around the consumption of alcohol during pregnancy indicate that alcohol is a threat to all pregnancies. Yet, there is a knowledge gap as to how alcohol affects the foetus and uncertainty over the effect of low levels of alcohol consumption during pregnancy (Leppo and Hecksher, 2011, Gray et al., 2009, Kelly et al., 2009, Henderson et al., 2007a, Abel, 2009) complicates the formulation of policy and recommendations to pregnant women. These paternalistic moralities encourage health messages to convince and educate pregnant women, giving the illusion that women are stupid and need to be educated. In this sense abstinence is just a sensible precaution. Leppo and Hecksher (2011) argue that the messages are vague, contradictory messages, with no further indication to the reasons behind the abstinence message. This coincides with the typical British way to advise and not tell. Discourses such as the medicalisation of motherhood, and the associations between the discussion of pregnant women who use drugs and alcohol give an insight into the issues of power and surveillance as developed by Foucault (1976, 1979, 2000) and the dominance of women bodies by men are influential here.

Recommendations regarding alcohol consumption during pregnancy have fluctuated between more permissive messages and a recommendation for total abstinence. The

adoption of total abstinence messages (such as can be seen in Scotland, The USA, Finland, Denmark, Australia with the strictest alcohol policy traditionally being found in the USA) has been accompanied by controversy, as this policy is based upon the principle of precaution rather than based upon research evidence suggesting that low or moderate levels of alcohol consumption during pregnancy causes harm (Leppo and Hecksher, 2011). The public health messages are unclear and are not backed up by clear medical guidance. Instead they appear to be based on moral judgements of which FAS are the latest medical response. Leppo and Hecksher (2011, p.7) argue that the change towards an adoption of a total abstinence model in Finland and Denmark 'is closely linked to a change in the social and cultural climate regarding FASD'. A review of the literature has revealed that the scientific conclusions have not changed. Instead the argument and the principles behind the recommendation for abstinence (Leppo and Hecksher, 2011) have been altered. This recommendation therefore errs on the side of safety, which may lead to the message being ambiguous.

## **Chapter 3. Methodology**

### **3.1. INTRODUCTION**

In this chapter I will discuss my approach to my empirical work in this research study. This chapter is split into two sections: firstly, I outline my methodological approach and explain why it was important to use a feminist epistemology for this research. I then examine the use of narrative methods, namely the Biographical Narrative Interpretative Method (BNIM) used. I offer reflections on its usefulness as a research method. I evaluate and examine the central debates on positionality and reflexivity in the research process before concluding with a discussion of the ethical issue apparent.

### **3.2. MY ONTOLOGY, EPISTEMOLOGY AND AN EXAMINATION OF POWER IN THE RESEARCH PROCESS**

One of the main motivations that gave rise to this research process is that I am critical of ‘master narratives’ (Romero and Stewart, 1999) that cast pregnant women as dangerous to their child, but also cast pregnant women as powerless and vulnerable. ‘Master narratives’ originate from dominant groups and work to reinforce the legitimacy of a dominant social position or differences in race, class, and gender therefore marking differences in power or in privilege as inevitable or even desirable, ‘they become part of how we see the world and, by implication, our research subjects’ (McCorkel and Myers, 2003, p.226). Such narratives have been criticised, for example by McCorkel (1998) that cast women who are incarcerated as dangerous. I wanted to ensure within this study that if women reported consuming alcohol during pregnancy that they were not constructed as dangerous and I do not wish to represent the women who I interviewed in this way. Instead I wish to give power to the women involved in this research to further the understanding of the social and cultural context of women’s alcohol consumption during pregnancy. In this chapter I will therefore detail the theory behind the methodology used in this research as I concur with the views of Skeggs (2002, p.17) who considers it important that research includes ‘a theory of methods which informs a range of issues from who to study, how to study, which institutional practices to adopt (such as interpretative practices), how to write and which knowledge to use’.

My research paradigm clearly shapes how I see the world, and how this research was constructed. In the examination of truth in research and the meaning behind it, I do not take a positivist stance (such as Durkheim (1950), Hacking (1983), Smith (1998)) which is used as a way of removing the researcher's subjectivity from the field (McGrath et al., 1993). Instead I believe that stories and knowledge that participants share are truths constructed through their social identity and lived lives in line with the work of Rose (1997) and Haraway (1988). Feminist epistemology critiques positivism and the idea of value-free objectivity (Wolf, 1996), whereas feminist knowledge has been described as 'contextual, inclusive, experiential, involved, socially relevant' (Nielsen, 1990, p.6), with feminist writers arguing that not only is being value-free and objectivity impossible but also undesirable (Wolf, 1996). I understand knowledge to be subjective, situated in and produced from social and cultural relations. This aligns with the view of Undurraga (2012) who considered that there is no such thing as raw experience, instead arguing that accounts of experience are produced in a social context, through and against cultural narratives. As Undurraga (2012) further considered that experience is mediated by systems of representation including language, discourse and dispositions. I therefore see individuals as active agents, although they are not isolated; experience is, therefore, located in social relations and constructed within the world in which they live (Acker et al., 1991). I also maintain a similar outlook to England (1994, p.244), in that I see knowledge as ongoing, with research therefore being part of a 'process not just a product'.

This current research parallels with principles of feminist theory, as I pay particular attention to issues around dominance and submission. I am interested in how our understanding is affected by these issues, therefore examining how the knowledge that we produce is, as described by Skeggs (2002, p.28) 'located in a nexus of power relations'. In following these feminist principles and the theory that the world is gendered, I concur with Rubin and Rubin (2005, p.26), who argue that 'open, loosely structured feminist methodology is necessary to learn about women, to capture their words, their concepts, and the importance they place on events in their world'. Throughout this research I have therefore used a feminist methodology similar to that used by Ettorre (1992), Maynard (1994), McGrath et al. (1993), Mitchell and Oakley (1979), Roberts (1990) and (Wolf, 1996). This includes a heightened

reflexivity and I have ensured that I have paid particular attention to power relations within the research, including recognition of how the researcher affects the process of discovery. Feminist theory promotes participatory and inclusive approaches and I have tried to make this research as inclusive as possible. As revealed in Chapter 2, I have an interest in power relations and surveillance, particularly the surveillance of women's bodies and the medicalisation of motherhood as discussed by Campbell and Ettorre (2011), Ettorre (2009), Lupton (1995), Oakley (1976), Oaks (2000). In choosing a methodology I have therefore ensured that I do not pick one that renders women powerless. Instead I have chosen to ensure that I understand the impact of gender and consequently have chosen to use a feminist stance in this research which seeks to further understand women's attitudes towards drinking during pregnancy and the gendered issues that are relevant. These include the medicalisation of women's bodies by the male, powerful medical profession that renders women powerless and the gendered nature in which alcohol is dealt with from a masculine perspective. My philosophical standpoint is therefore a feminist one, similar to that of Stanley (1990), Stanley and Wise (1990) and Maynard (1994).

Rubin and Rubin (2005) reveal how, as researchers, our positionality and actions affect the research that we complete. It is therefore imperative that we strive for reciprocal relationships between the researcher and participants, via empathy, and mutual respect. Feminist research practice is concerned with hierarchical power relationships within research (Undurraga, 2012, Letherby, 2003, Millen, 1997), and although problems of inequity may creep into the research process, a continual awareness of it assists in attempting to resolve these problems. Feminist research seeks to remove the unequal power hierarchies that often exist within research (Wolf, 1996), seeking to give the researched more power in the research process (Cancian and Armstead, 1992). A consciousness towards power within the research process helps to ensure that participants who are researched are treated like people and not as England (1994, p.243) describes: 'mere mines of information to be exploited by the researcher'. A priority is therefore to ensure that the relationship between the researcher and the researched is not an exploitative one. Therefore we are ensuring that the participants in the research are not stigmatised or manipulated in any way (Acker et al., 1991). As Skeggs (2002) indicates, because feminist

theories take women and power into account, they are usually more adequate to developing an understanding of the lives of women.

England (1994, p.250) emphasises that hierarchal relationships can exist within all research, and that 'reflexivity can make us more aware of asymmetrical or exploitative relationships, but it cannot remove them'. This argument reveals how the researcher to some extent thus has an involvement and therefore some power in the research as England (1994, p.249) continues 'the researcher cannot conveniently tuck away the personal behind the professional, because fieldwork is personal'. An understanding of power in the research process is therefore important. We therefore need to be aware of the differentials of power in the research process, and be reflexive to ensure that the relationships, we as researchers have to the subjects of our research, are more even by promoting inclusive approaches and ensuring that the women involved in the research are not powerless. The methodology I chose for this research helps to shift the power position of the researcher from a knowing subject, to a passive participant in the data collection (Jones, 2004, Bolton et al., 2005). It works to hand power back over to the respondents, giving them more control in the research process and avoiding misrepresentation. Also by following this feminist practice I assume that a participant's knowledge of the subject matter will be greater than that of the researcher and treat the participant respectfully.

### ***Research strategy and methodology***

I am interested in understanding women's use of alcohol in pregnancy in Scotland but I also understand the importance of themes such as power, surveillance and gender. Through my research I intend to explore why women may or may not choose to drink during pregnancy, and their attitudes towards alcohol. I also go on to consider the social context within which women drink. Understandably, the use of different methodologies may produce different knowledge and therefore different results (Undurraga, 2012). I therefore have used qualitative methods which enable the collection of data offering a better explanation of the personal issues which are present. These techniques, for example the use of focus groups and interviews, allow for a better understanding into lived experience, individual values and beliefs can therefore be examined in more detail than a quantitative study would allow. I aim to understand the women's knowledge and feelings of alcohol consumption. By

researching understanding, I hope to gain an insight into the processes such as power which shape our social world. What are defined as qualitative methodologies are therefore highly suited to investigations into individual decision-making processes, ensuring that the 'how' and 'why' are explored, and therefore assisting in the understanding of why people behave in certain ways. How social actors interpret the world and their place within it will therefore be revealed (Harlow, 2009) and it is therefore ideal for investigating the subtle, controversial, and unknown (Popay and Williams, 1996).

Qualitative research methods are directly concerned with social action as it is lived and experienced (Blaxter et al., 2001) leading to a more in depth analysis of the social world (Sarantakos, 1993). Interviews, unlike surveys, enable researchers to produce rich, detailed data about social behaviour through the exploration of normative discourses, processes and meanings; they are able to get to the processes behind human action, providing a more detailed picture than is possible through some quantitative strategies.

I would argue that narrative methods give more flexibility than perhaps semi-structured interviews would offer. Although semi-structured interviews do allow for the response to be structured by the account of the participant (Watkins et al., 2002), the use of narrative methods ensured as little interviewer intervention as possible. Maxwell (1996) argues that the use of lists and prompts within semi-structured interview methods imposes a framework on the interviewees responses, which may prevent them talking about the issues that really matter to their own lives. The use of a narrative method therefore ensured that the participant set the issues for discussion, not I, as a researcher. The uniqueness of individual experience was therefore not stifled within the interviews.

Since the underpinning purpose of this study was to examine women's attitudes towards alcohol consumption during pregnancy, the study utilises methods, as Charmaz (2002) expounded, to enhance the presence of the thinking, acting, feeling person in the research. By examining individual experiences and specific phenomenon, the interviews that I use allow an examination into the lived experience of the mothers who participated. This allowed me to engage with the social behaviours and develop a further understanding of the social structures in their



lives. As previously examined in Chapter 2, some researchers indicate that the discussion of alcohol is a sensitive topic (Plant, 1986). Because of this I have chosen to use narrative research. As Bolton et al. (2005) argues, the use of narrative interviews would not attempt to elicit facts relative to a researcher's own interests unlike other more structured methods of interviewing as semi-structured or structured interviews. Semi-structured interviews would therefore not allow for a deep understanding and would also not give the participants as much power in the research process as the use of narrative methods entailed. I did not wish to use a structured interview schedule for this data collection as I thought it might limit the scope of the data collected and ignore the real issues behind the choices that women make regarding their alcohol consumption during pregnancy. Focus groups could have been used for this study as they have the potential to enlighten various structural factors that influence decision making (Watkins et al., 2002, Popay and Groves, 2000). However given the individual experience of childbirth and the potential stigma that could arise from revealing the consumption of alcohol during pregnancy, I felt it would be better discussing these topics on a one-to-one basis with women. I was highly interested in the individual experience and consequently looked at the use of narrative methodology, leading to the adoption of a narrative technique within this study.

### **3.3. NARRATIVE RESEARCH**

Narrative methods of inquiry have received increased attention within the academic community. Its recognition as a useful analytic tool for a wide variety of research questions across an extensive range of disciplines (Elliott, 2005, Frank, 1995, Hollway, 2000, Mishler, 1986, Riessman, 2008, Wengraf, 2001, Balsamo, 1999, Jones, 2004, Lawler, 2002, Riessman, 2005, Abrahamson, 2012, Harlow, 2009, Holt, 2010, Ohlen, 2003, Ricoeur, 1980, Riessman, 1989) has gone hand in hand with a general increase in attention towards the lived experience of individuals (Bunton and Crawshaw, 2006, Evans, 2006, Thompson and Kumar, 2011). By examining a narrative, researchers are able to gather the meanings of different events for individuals, producing very detailed and authentic accounts full of personal experience (Riessman, 2004). Identity is bound up within the social world (Harlow, 2009) and narrative is itself a social product. People construct identities by locating themselves within the social and integrate their experiences into narratives.

Riessman (1989) argues that most, if not all, narratives have a recognisable structure with a beginning, a middle and an end (Mason, 2002), the production of which consists of the organisation of a chain of events into a whole, whereby ensuring that the significance of each event is understood through its relation to that whole. It is therefore this connected unfolding chain of events by which we are able to organise experience and infer causality. Elliott (2005) argues that because narratives are usually representative of a chronology, the meaning behind the event is understood from an examination of the sequence that they follow and from the social context in which the narrative is recounted. Certain events and decisions are reportable by virtue of their significance or their unusual or unexpected qualities, for example stories about the death of a parent, or the birth of a child. These events clearly have an emotional significance to the individual who recounts them (Elliott, 2005). As a method, it therefore conveys the meanings of events and their implicit significance to the narrator, identifying as Holt (2010) describes the ‘whys’, ‘how’s’ as well as the ‘what’s’. Narrative methodologies provide a rich source of data and the use of narrative is therefore an important element of social research.

Narratives as social products produced by people within the context of specific social, historical and cultural locations. They are related to the experience that people have of their lives, but they are not transparent carriers of that experience. Rather, they are interpretative devices, through which people represent themselves, both to themselves and to others. Further, narratives do not originate with the individual: rather, they circulate culturally to provide a repertoire (though not an infinite one) from which people can produce their own stories

(Harlow, 2009, p.242)

An interview can be viewed as a speech event (Mishler, 1986) and Gee (1985, p.9) concludes that the process of ‘narrativizing experience is a basic human trait’. Individuals have a narrative identity as they (we) tell their (our) experience. As Elliott (2005, p.1) purports; ‘recent work on the nature of the self, which destabilizes the concept of the individual as having a fixed, immutable, identity, has led to theoretical interest in the idea that people might be thought of as having what has been called a ‘narrative identity’’, that is to say that the narrative identity is one

constructed by an individual when they are telling their tale, the narrated self therefore comes out in this account. A narrative is therefore highly expressive as it ‘conveys the narrator’s *explicit* assumptions and norms as well’ (Wengraf, 2001, p.116). Our own positionality is embedded within the stories which we tell and, for this reason, narratives which are rich in data are powerfully expressive. Narratives act as what Wengraf (2001, p.116) describes as ‘the natures of particular persons, cultures and milieu’. They are valuable because they present to the researcher both embedded and tacit assumptions, therefore giving greater credence to meanings and patterns of action or inaction and the individual’s understandings.

Ricoeur (1980) argues there is a time aspect to narrative as producing it is a reflexive act. Narratives therefore present an opportunity for the interpretation of the past as individuals recollect and communicate their experiences. It therefore is a central way by which people connect their selves to the past and the present by interpreting the past through the knowledge and experience they have gained. Stories do not always exactly replicate experience, sometimes there exists a disparity between lived experience and accounts of it (Charmaz, 2002). Stories are told and re-told and therefore new versions of the story may become created within this process as the narrator improvises and interprets meanings, As Charmaz (2002, p.307) explains; ‘after participants grant a story narrative truth, retellings of it may give rise to new versions and narrative emphases’. Narratives thus reveal a transformation of time, as Harlow (2009) argues the past is seen through the lens of the present. Narratives consequently have an evaluating significance, as participants make sense of their experience, understand it and then give meaning to it. It offers, as Riessman (2004, p.3) purports, a way to ‘re-imagine lives’ as individuals give significance to their stories and give meaning to them. The past is therefore recounted through a process of interpretation and is therefore reinterpreted.

Narratives do not mirror the past, they refract it. Imagination and strategic interests influence how storytellers choose to connect to events and make them meaningful for others

(Gee, 1985, p.3)

Narratives therefore allow the past to be interpreted, giving the interviewee the task to make sense of their experiences during the interview rather than simply

reproducing the past how it was. The past is therefore revised and edited (Riessman, 2008) allowing a critical awareness to be created which allows for a better understanding for why actions have taken place. 'The narrative mode of thought refers to the premise that our lives are not lived passively: we actively attempt to understand, to interpret, and to explain them through the stories we construct to make sense of human experience' (Kirkman, 2008, p.242). In this sense, narratives create meaning rather than a simple act of retelling a story, linking life events and establishing meaning (Fry, 2010), as they accord with other broader social narratives, drawing for example from public narratives (Harlow, 2009). They therefore have a great potential for shaping understanding (Graham, 1984).

A story may also be told differently, depending on the audience it is being told to. As Mishler (1997) mused, one retelling of many of the stories she might have been told, could have been influenced by the researcher. Undoubtedly the story would have been different if there had been another interviewer. A narrative may also change as it constitutes a performance enacted for a particular audience; therefore, narratives don't begin or end within the research interview or setting (Harlow, 2009). Other researchers have noted the usefulness of narrative at times of fluidity and change as Shelton and Johnson (2006, p.318) indicate 'a narrative analysis might highlight how women adjust to motherhood over time and give the opportunity to explore diversity in stories'. It is thought that the use of the narrative is therefore good for expression of motherhood experiences, a period of time where women experience great change (Hunt et al., 2005, Lois, 2010, Miller, 2005, Radcliffe, 2011a, Shelton and Johnson, 2006). This experience is lived, as mothers experience a change in self and a bodily change.

As a research method, there exists less chance for the management of the story by the participant when using a narrative method of inquiry. As Wengraf (2001, p.118) argues 'narrative is particularly difficult for the speaker to control completely, and therefore it provides less capacity for conscious and unconscious manipulation by the speaker'. I would argue that the narrative produced is therefore more natural, than perhaps a response produced through other forms of interviewing would be. This is an important feature for choosing to use narrative research methods in the field of alcohol research. I am drawn to narrative methods due to their treating participants as active agents in control of their life story. The benefits of using a

narrative approach for my research into women's alcohol during pregnancy were recognised. A narrative approach to my personal experience research led to an examination and use of a biographical narrative methodology, which would allow for a life course approach. There has been an increase in the uptake of biographical research within the social science

### **3.4. THE USE OF THE BIOGRAPHIC-NARRATIVE-INTERPRETIVE METHOD (BNIM)**

I decided to adopt a Biographic-Narrative-Interpretive Method (BNIM) for the primary data collection. This established research method is built upon the work of Rosenthal (2004) and is structured around a mode of narrative questioning, in order to reconstruct a biography. The focus of the interview is on 'biography and its methodical and sociological elaboration' (Wengraf, 2001, p.112). Biographical narratives have been shown to be especially useful in accessing aspects of human behaviour (Zinn, 2005, Wengraf, 2001). As argued biography is viewed as a social construct of social reality (Rosenthal, 2004) as the presentation of past events is reconstructed from current and previous life experience. It is therefore important to acknowledge how narratives are historically situated, and the life course approach to the BNIM interview is therefore important because of this:

This biographical reconstruction is not restricted to the sociological understanding of persons (as acting units in society) but is also aimed at the understanding of society in its historical and social structures (limiting and enabling interaction

(Wengraf, 2001, p.113)

The BNIM interview is based on 'the elicitation and provocation of storytelling' (Wengraf, 2001, p.111) with the aim to elicit a narration (a life story) which will focus upon 'part or all of the individual's life story, their biography' (Wengraf, 2001, p.111). Buckner (2005) assumes that narrative expression is closest to people's lived experience as it gives an example of conscious concerns but also is influenced by the less conscious cultural and social presuppositions from individual's lives and the life stories they tell. It therefore allows for a deeper understanding of individuals lives in

context, and this is a strength of the method as Chamberlayne (2004) argues it allows the connection of policy with lived experience.

I recognise that the use of biographical structures enables a reflection on experience (Jost, 2012). Having examined different types of narrative approaches to research, I decided to follow the BNIM approach. This method has been used successfully by other researchers, for example, by Bolton et al. (2005); Brooks and Dallos (2009); Froggett et al. (2005); Jones (2003); Miller (2000); Meares (2010); (Roseneil, 2012) and Suárez-Ortega (2013) to provide rich information on actions and their context. BNIM interviews also reveal the intentions and meanings of the individual, therefore providing an example of ‘multiple realities’ which Stakes (1995) claims are what researchers aim to examine. I thought this particular narrative method would be most appropriate given its orientation to the exploration of life histories, lived situations and personal meanings (Roseneil, 2012).

As this research seeks narratives of past experience, I thought BNIM would be a suitable method as it reveals social experience just as it appears in its everyday manifestations (Kenway and McLeod, 2004) and the biographical method is intimately related to the shaping of existence. The BNIM method is similar to ‘free association narrative interviewing’ (Hollway, 2000) as it is highly participant-centred in the interviewing phase, however it differs as free association narrative interviewing is more concerned with narrators’ emotional sequencing of their stories (Squire, 2008). Given that I was looking at a life-course perspective, I felt the BNIM was more appropriate than this or other autobiographical narrative methods (Smith and Watson, 2010, Harrison and Lyon, 1993, Taylor and Bogdan, 1984). The BNIM interview method allows for more biographical discussion and reflection of participants. As Squire (2008) purports, researchers who are interested less in biography, more in differences across groups of individuals, tend to use larger interviewee numbers, so I thought the sample size was suitable for this study.

### ***The Single Question Aimed at Inducing Narrative (SQUIN)***

The biographical narrative-interpretative method, as developed by Wengraf (2001), is a multi – session technique, consisting of a total of three sub-sessions, although the third sub-session is optional. Throughout the interview it is intended that interviewer interventions are restricted, this involvement is constrained within sub-

session one to an initial single question designed to induce a narrative (SQUIN) and interviewer interventions remain very restricted until the second sub-session. There is therefore no structure imposed onto the participant apart from giving them an awareness of the project. It is the SQUIN that therefore determines the response of the participant and an important feature of the methodology is that this question is not followed-up, or developed further during the sub-session (Wengraf, 2001). The researcher therefore does not elaborate upon the SQUIN once it has been asked, or 'spell it out' in any way. The interview therefore has minimalist interviewer intervention and silence is critical to the method. As Wengraf (2001, p.113) purports 'for as long as possible you give up control, refuse to take up offers of partial control, and maintain the maximum of power-asymmetry against yourself'. Interventions by the interviewer throughout the first sub-session are in effect limited to facilitative noises and non-verbal support, which actively support the interviewees and work therefore by ensuring that the interviewee is not disturbed so they are therefore able to follow their own system of relevancy (Wengraf, 2001). By restricting interviewer interventions it therefore allows the participant to not be distracted or interrupted during the production of their narrative. Adopting the Wengraf (2001) approach to BNIM, a SQUIN was developed. The following SQUIN was used for all interviews both in Edinburgh and Inverness:

I am interested in your experiences of pregnancy and motherhood. I would like to find out about the health choices that you made before, during and after pregnancy for example your diet, exercise patterns, smoking, drug use and your choice of feeding type for example whether you breastfed or bottle-fed.

I am especially interested in your alcohol consumption; I would like you to tell me your story, you can begin where you like although perhaps you could begin by telling me about your earliest memory of drinking or being around alcohol.

I won't interrupt I'll just take some notes for afterwards

This approach is useful as the participant still determines what story is told, by defining what was particularly important to them in their life. The use of narrative interviews meant that this was possible as women were given scope to tell their own

tale. Pauses feature prominently within this research method, and the lack of interviewer intervention exacerbates this. It is important to recognise how pauses are an important part of the methodology, and assist the participant in the production of their biography. In the first sub-session only one question is to be asked by the interviewer, this is the SQUIN, and all other interviewer interventions are minimal, restricted to facilitating noises.

In the second sub-session the only questions that can be asked are also narrative questions. However these are defined by the topics that had been spoken in the first sub-session, based upon things that the participant has mentioned. It is imperative that these questions are asked following the order in which they appeared in the narrative and at all times use the words that were produced in the narrative. These questions are defined as Topic Questions Aimed at Inducing Narrative (TQUINs) (Wengraf, 2001). Not all topics mentioned need to be covered, however it is a prescribed form of the methodology that an earlier topic cannot be mentioned once a later one has been addressed. Just as the narrative in sub-section one has a particular sequence of topics; these topics are raised in sub-session two in the same order. Topics may be missed out but it is important that an earlier topic is not explored if a later one is mentioned within the second sub section of the interview. Wengraf (2001) argues that this is done to ensure that the intervention of the interviewer does not terminate the gestalt of the participant. For this sub-session, therefore, it is important that notes made in the first sub-session are followed accurately. The methodology for the second sub-session ‘involves a constant gentle pressure on the informant to provide more narratives and narrations’ (Wengraf, 2001, p.133), as each TQUIN involves asking participants for more narrative. Questions such as ‘can you give me any example of an occasion when? Can you give me any more examples of similar events, incidents at that time / of that type? Was there some particular crucial incident or situation that you can recall?’ (Wengraf, 2001, p.141) are to be used and I followed these requests for examples.

Wengraf (2001) argues that if asked for a narrative by way of a narrative-pointed question, the provision of a non-narrative is illuminating as it highlights a decision to not respond. This sometimes was a feature in my research, and sometimes it felt that I was probing for more narrative, although the questions asked here were formulated by the participant’s initial response. As the interviewer I still chose what topics were



to be used in sub-session two. As a researcher I therefore have to acknowledge the importance in what topics I chose to expand upon and to some extent it could be argued that this is an attempt to elicit facts relative to a researcher's own interests. During the second sub-session it was evident that some women struggled to provide more narrative, feeling as though they had already told me everything that was relevant, and in this case the interviewer provided non-narrative or just repeated what they had originally said.

The third sub-session, offers a chance to ask the participant further questions along topic lines that they have not already mentioned. This is usually done at a later date in a follow up session. However as an optional session I did not include this, not wishing to disturb the participants again and I felt that they had told me all they wanted to on the subject matter. Some women did call or write notes at a later date to tell me things that they had forgotten but I felt that this third sub-session was not needed.

### ***A critical reflection of the use of BNIM and the limitations of the method in the research***

Narratives are historically situated in the life course and BNIM is useful for exploring lived-experiences. I felt as a method this worked well for the discussion of pregnancy. As most women started their narrative with their first memory of drinking, the narrative followed the life course until pregnancy, and this allowed for alcohol to be examined as one aspect of pregnancy, instead of a separate topic. Time will have shaped the perception of pregnancy and drinking; however, as I have already argued, the BNIM interview allows for the re-evaluation of the narrator of life experiences.

The life story interview is a method for looking at life-as-a-whole and is useful for the in-depth study of individual lives (Atkinson, 1998). The biographical interview differs from other forms of interviewing in that the interviewee rather than the interviewer dictates the content, length and direction of the narrative (Rosenthal, 2004). Ni Laoire (2000) argues that a biographical approach facilitates a more in depth understanding of the structural conditions in which action occurs and is especially useful in accessing the unknown features of human behaviour. The women within this research were willing to open up and reveal themselves to the

researcher. Removing some of the power inequalities that may exist within research interview situations (Wengraf, 2001) meant that the interview format enabled the participants to set their own agenda and pace, offering greater control in the interview situation. This research method aligned with my feminist ideals in that it was emancipatory research, for and with people (Faulkner and Layzell, 2000). Moreover, biographical methods are a useful way of accessing themes that may be difficult to articulate. These methods offer marginalised groups or what Mishler (1986) entitles 'revolving door' patients the opportunity for their voice to be heard within a potential stigmatised issue. In line with the findings of Rosenthal (2004), I found biography particularly useful in generating new ideas and thematic connections that had not previously been considered within the study.

There are limitations of any data collection method and there are a number of weaknesses associated with the BNIM approach. Firstly Sarantakos (1993) argues that due to the greater interaction between researcher and respondent in qualitative research, it can be difficult to generate reliable, representative and generalizable data. Maxwell (1996) also argues that qualitative data are liable to inaccuracy because of the ease by which the researcher can impose their own agenda. However I would argue that the use of BNIM limited this.

I have to be aware that biographies are not an unmediated guide to the truth of social agents values and actions, rather they are partial and biased accounts of events and, as such, there will be inconsistencies, gaps and contradictions in the information participants reveal (Jost, 2012). I understand therefore that biography is thus not a true representation of events but must be understood as a process by which individuals can arrive at an understanding of their present situation and social identity by determining the significance of past events in shaping their life trajectory. This is linked to the performative nature of narratives (Schulz, 2011).

Another limitation has been contended to be that the researcher objectivity is removed as the researcher knowledge on the topic is increasing from one interview to the next. Jovchelovitch and Bauer (2000) argue therefore that the knowledge of the interviewer cannot be hidden for long. However as the participant sets the interview schedule within BNIM interviewing, I think this was minimised within this research. Jovchelovitch and Bauer (2000) also question whether the prescribed

format of the 'initial topic' is suitable for every participant. My research demonstrated that due to the individual nature of this subject, women who even abstained from alcohol still had an important contribution to make.

The data produced from the BNIM interview are complex and muddled, which some have argued makes it difficult to analyse. This can make analysis problematic and time-consuming but this in itself is useful because it highlights the highly different and individualised narratives given by each woman. It can also be difficult to convey such in-depth insights that are gained through the use of narrative research methodology within academic writing where there is a convention to use short quotations rather than long narratives to support an argument.

### **3.5. REFLEXIVITY, POSITIONALITY AND POWER IN THE RESEARCH**

Again, returning to the theme of power in the research process, I examine how, reflexivity forms a fundamental part of the research process as it allows researchers to recognise the role of power that exists within research. Reflexivity is a 'methodological stance' (Kenway and McLeod, 2004, p.526) and is, therefore, scrupulously examined within scientific research. It suggests a process of self-awareness and self-critique whereby we, as researchers, are 'reflexive about one's role and effect as a researcher' (Kenway and McLeod, 2004, p.526) and therefore are open to internal and external scrutiny. A 'strong reflexivity' is therefore subjecting ourselves as researchers to the same level of scrutiny that is given to the research participants (McCorkel and Myers, 2003). Recently within research there has been an increasing attentiveness to what happens in 'the shadow's' (Goslinga and Frank, 2007), the real practices and experiences hidden within fieldwork are often negated by researchers (Leibing and McLean, 2007). However considering these shadows, we can explore not only the impact of the researcher on the work, but also the work on the researcher, as Buckner (2005) argues researcher influence is inevitable in all research.

It is important, therefore that I recognise how my voice is present within the research process. As the instigator of this research, I have set the outline for the interview, and my own interest in the topics has set the agenda behind the research. I have therefore endeavoured to follow Foucault's relations of power which entails 'not overstepping

my authority and privilege as a researcher and working to avoid misrepresenting research participants' (Huckaby, 2011, p.174). It is, therefore, important that I reflect upon my position as researcher and identify how my own biographical perspective may impact on the relationship that I had with the research subjects. It is important therefore to understand the role of researchers in the production and analysis of data (Hollway, 2000) and the role of researcher subjectivity has long been an important issue within academic research. Bolton et al. (2005, p.9) argue that 'the turn to narrative inquiry shifts the very presence of the researcher from knowledge-privileged investigator to a reflective position of passive participant/audience member in the storytelling process'. In this respect, 'the researchers responsibility is to be a good listener and the interviewee is a story-teller rather than a respondent' (Hollway, 2000, p.31) .

Undurraga (2012) argues that although an awareness of power issues helps, that it is an illusion to believe that the participant and researcher hold the same position of power. Romero and Stewart (1999, p.228) argue that 'the researcher's positionality cannot be erased completely'. Mason (2002, p.231) also argues that 'the types of questions an interviewer asks, and the way they listen to and interpret the answers they are given, undoubtedly help to shape the nature of the knowledge produced'. An understanding of this highlights how the data collected cannot be fully understood without some acknowledgement of the audience for which it has been produced. As observed:

At the most basic level, an individual will need the 'conversational space' to tell a story to another person. The narrator needs at a minimum the co-operation of a conversational partner...the listeners therefore immediately become active co-participants in the recounting of a narrative. The story produced within a narrative is therefore constructed within the context of the interview 'rather than being a neutral account of a pre-existing reality

(Elliott, 2005, p.10)

McCorkel and Myers (2003, p.208) argue 'privilege and self-interest are implicated in the production of knowledge-shaping what we chose to write about, whom we shared our work with, and whose voices we silenced'. By recognising our role as researchers and reflecting on the process of knowledge creation, it enables us to

pursue knowledge more rigorously and to improve our understandings of the social world. The standpoint of the researcher therefore needs to be acknowledged as the production of knowledge is a subjective rather than objective process.

### **3.6. FRAMING THE RESEARCH METHODS AS A HEALTH AND LIFESTYLE PERSPECTIVE**

It is evident that within the use of BNIM, the researcher needs to decide how much project awareness that the women should have as their awareness of the project will impinge upon the narrative, as Wengraf (2001, p.121) states ‘you will need to have decided, prior to this initial presentation of the project to the prospective interviewee, how strong and clear or how weak or fuzzy you wish their awareness of project details to be’. As argued in Chapter 2 the discussion of alcohol can be deemed a sensitive topic due to the sensitivities presented by this research in dealing with potential drinking problems, I considered that BNIM is a suitable methodology for my data collection. As Elliott (2005, p.135) describes ‘even when research focuses upon a topic that might not be expected to be sensitive or disturbing for respondents, once interviewees are given the space to provide stories about their experiences some unexpected distressing accounts can emerge’. The discussion of pregnancy, motherhood and alcohol consumption is a very personal and potentially emotive issue, and other sensitive topics were touched upon in some of the interviews such as domestic violence, post-natal depression and miscarriage. In my research into women’s alcohol consumption during pregnancy I therefore had to closely consider how best to approach this research topic, and consequently had to consider the various recruitment and methodological issues that existed around talking to women about alcohol consumption during pregnancy. This led to my framing my research within a health and lifestyle perspective and the choice of a narrative method that would allow handing over the structure of the interview to the participant (Gillham, 2005).

I was concerned whether women would want to speak openly about their levels of alcohol consumption during pregnancy for risk of being stigmatised as a ‘bad’ mother. I had to consider whether women would be open to talking about their alcohol consumption during pregnancy. Although, this is not an illegal activity, it is a behaviour that has become socially stigmatised within the UK (as the work of

(Gabe, 2005, Murphy and Rosenbaum, 1994, Radcliffe, 2011a, 2011b, Campbell and Ettorre, 2011, Oaks, 2001, Armstrong and Abel, 2000, Barrison and Wright, 1984, Connolly-Ahern and Broadway, 2008) reveals). The media representations also reveal this (Barnes, 2012, BBC, 2006, 2012, Bennett, 2007, Child, 2012, Foster, 2007, Geddes, 2012, Hope, 2007, Laing, 2012, Laurence, 2008, Scotsman, 2006, 2007a, 2008c). Women may fear having their mothering judged to be not good enough and there is also a fear that by admitting to consuming alcohol during pregnancy, they may risk being labelled as an alcoholic, or revealing alcohol issues for some women lead to a fear that they may risk losing their children. I was therefore careful to defend their anonymity.

Evidently, there is a challenge in eliciting narratives from individuals within research, which is more complex when sensitive topics are pursued. I had some concerns about the sensitivity of the topic and I wanted to ensure that I was sensitive to the emotional needs that the research may involve (Lawler, 2002) and this is why I decided upon the use of a health and lifestyle perspective. In choosing the SQUIN for this thesis, I chose to examine alcohol consumption within the locus of health and lifestyle choices. This was done to recognise how the consumption of alcohol is often related to other cultural and social aspects of life and therefore, cannot be dealt with as an entirely separate subject. As alcohol consumption during pregnancy could be seen as a stigmatised activity and therefore a potentially sensitive topic, it could have possibly posed a struggle to the recruitment of women. To negotiate this pitfall, I chose to frame my study using a life course perspective, focussing on health and lifestyle choices. This was not done with a covert agenda; indeed I examined women's alcohol use in relation to other health related behaviours. I informed women that I was 'Interested in your health and lifestyle choices during pregnancy'. It is important to note that I did not specifically recruit women with issues around alcohol or who were problem drinkers. However the use of BNIM as a method allows the respondent to tell their story, and explain their experiences of alcohol consumption and other behavioural choices. This life-course perspective allowed women to talk more openly about how being pregnant affected their alcohol consumption without feeling that they were being judged on their lifestyle choices, before, during and after pregnancy.

The research has been designed to take it into account that sensitive topics will be discussed during interviews. One advantage of this as a method is that the interview is constructed around the respondent's own narrative as the participant is given the freedom to talk openly about any issue without interruption. The respondent therefore has considerable ownership over the interview and controls what is discussed. In this respect, a respondent will only talk about a 'sensitive' topic, if they want to. For example although participants did mention or talk about 'sensitive topics' during their interview, they were not specifically asked to talk about these. The potential risk of harm to participants was therefore minimal, and this minimised any effects of the research project.

All of the issues spoken about by the mothers in the interview were important, as they all form a part of the plot of their narrative. However the women interviewed didn't always talk about alcohol, instead they sometimes focussed on what was important to them, I didn't 'attack' them about alcohol and this serves to illustrate how, for many women, drinking is not an isolated topic or one point in life specifically. During pregnancy a woman's whole history around alcohol is important as the experiences she has had around it may have transformed her identity. This emphasised that through 'emplotment' (Lawler, 2002) prior events lead to later ones. Discussions were, therefore, wide ranging and covered a number of topics including alcohol; for example, alcohol was discussed in conjunction with food. From each of the women's narratives, alcohol was not a wholly separate topic. Issues or ideas which they had around alcohol, seamlessly flowed together with other issues.

The use of a health and lifestyle perspective enabled me to see alcohol use as embedded in lifestyle behaviours. I was however sufficiently uncomfortable with the idea of concealment so I did mention my special interest in alcohol in discussion with women both at the recruitment stage and also in discussion before the interview commenced. I also made it clear within my opening question aimed at inducing a narrative that I was interested in women's health and lifestyle choices around pregnancy, and that I was especially interested in their alcohol consumption. I therefore made women aware that I was specifically interested in their alcohol consumption but overall was interested in their personal experiences and what they saw as important to them. I also suggested that women start their narrative by talking about their earliest memories of being around alcohol or drinking. This was chosen

to enable a lifestyle perspective and to allow women to start their narrative from their youth and then continue their story into the present. This allowed a lot of women to discuss the impact of different relationships or their family's relationship on their choices around alcohol, which were built upon in the second part of the interview.

Within health research it is not uncommon for drug use, alcohol consumption and smoking behaviours to be critiqued and analysed as separate behaviours, thereby distinguishing them as distinct, separate topics. By doing this, it disregards the way in which they are highly interconnected issues (Ettorre, 1992). For instance, an analysis into the growing up in Scotland study (Ford, 2008) indicated that women appeared to choose their vice while pregnant, choosing to either smoke or drink alcohol while pregnant as opposed to continuing both health behaviours together. It is also evident that some of women's attitudes around smoking during pregnancy are the same as around alcohol, for example influenced by guilt or surveillance. By framing my study in this way it enabled me to give women a chance to talk about other health behaviours and the way in which alcohol was a part of other choices within pregnancy. This gave women the chance to talk about issues that were individually important to them.

I didn't feel uneasy with this choice of framing and methodology, my only worry going into data collection was that women would only talk about general health issues and not about alcohol or would also base their whole narrative on the birth story. This is clearly a large part of women's experience of becoming a mother and featured prominently within every interview.

On reflection participants reacted well to this. Women spoke about alcohol in their opening narratives but also discussed other health related behaviours. For some women it was evident that although alcohol was part of the narrative it was not the only thing that women spoke about as being important. For example, for one participant Elsie, alcohol played a large role in her life and within the first minute of her narrative she revealed that her father had been an alcoholic and that she also had issues around alcohol. What is interesting is how, despite this, alcohol only formed part of her narrative. Across the interviews, women were asked to tell me a bit more about their alcohol consumption or experiences around alcohol where they had mentioned them. The women did not react to this probing, as it had been made clear



to them that I had an interest within alcohol consumption and although probes were asked regarding alcohol, each participant were also asked about other things that they had mentioned in their narrative such as smoking, or other experiences and conversations with friends, family and the medical profession. On reflection women reacted well to the narrative questions, they did not mind being asked further about their alcohol because they were asked to talk about other things as well. The only negative side to the probing was that sometimes women felt that they didn't have anything more to say on that subject, they felt that they had told me everything and could not elaborate any further. It is important to note here how there can be therapeutic qualities (Oakley, 1981) of a narrative interview as 'people can benefit from being given the opportunity to reflect on and talk about their lives with a good listener' (Elliott, 2005, p.137). I would like to note many respondents' positive evaluations on the interview process with some respondents contacting me at later dates to provide further information either by a telephone call or by including more information on post it notes attached to consent forms where the interview had taken place on the telephone.

I feel that the use of a health and lifestyle perspective worked well and I was successful in recruiting women to be interviewed. In total I conducted 22 interviews; however one woman withdrew from the study after receiving her transcript. After each interview I asked each participant if they would like a copy of their interview transcript. One woman asked for her transcript then, shortly after receiving it, asked to withdraw from the research as when she had read over the interview she didn't feel like the verbatim transcript gave a very good description of her experience and did not feel that the transcript represented her. I feel this aligns with the views of Poland and Pederson (1998) in their explanation that some participants feel 'unsettled at seeing their testimonies presented in writing in a format removed from the interview discussion and potentially available to others' (Poland and Pederson, 1998, p.300). This is true of the woman who chose to withdraw from the study, who emphasised that she didn't see herself in the transcript. This potentially represents how the interview is a collaborative process (Undurraga, 2012, Oakley, 1981) and how, when telling stories, sometimes we present different versions of ourselves. On reflection, this woman did not feel that this represented her experience and at her request her data were removed from this study.

### **3.7. THE DATA COLLECTION AND DEVELOPMENT**

#### **3.7.1. The study areas**

It was identified that two localities would be used for the study; to ensure that there was an inclusion of North and South and Urban / Rural Scotland. This urban / rural difference was thought to be especially important as previous analysis from the Growing up in Scotland (GUS) study revealed that there is a strong pattern of alcohol consumption in rural areas during pregnancy (Ford, 2008). An examination of the findings from this study revealed that unlike the findings of the growing up in Scotland study, geography did not appear to play a role in women's decisions around alcohol. There were no substantive differences between women's narratives from women in both urban and rural areas, around alcohol consumption. Differences instead arose between urban and rural areas of a more social nature, with differences in childcare arrangements and the facilities available to women during pregnancy and support post-pregnancy. Due to these locations being distant from my home, I therefore became stretched across the two sites, having to split the time I had available for data collection between them. This however meant that I did not have the opportunity to get to concentrate research specifically in one site, potentially if I had instead focussed on one site I may have been able to make more connections with more women. If I had just focussed on one site, such as Edinburgh I may have been able to recruit more women, as recruitment proved easier in Edinburgh. However this criticism is retrospective

Women's alcohol consumption patterns are also closely linked with place as changes in gender differences are often slower in rural areas (Valentine et al., 2012). An analysis from the Growing Up in Scotland (GUS) data (Ford, 2008) also indicated that during pregnancy there was a difference in women consuming alcohol in urban versus rural areas, with higher levels of alcohol consumption during pregnancy being found in rural areas (Holloway et al., 2009). Chapter 4 examines the importance of lay knowledge and as Macintyre et al. (2005) argue lay perceptions of health are likely to differ with place.

The two areas of Edinburgh and Inverness were chosen as both have a high prevalence of alcohol consumption. Edinburgh, the capital of Scotland, has a high population density and Inverness is a far more rural area. In part the choice was

pragmatic as both cities were easily accessible and both have a large number of mother and toddler groups to approach.

Specific alcohol consumption data are not currently available for Inverness and Edinburgh; however Scottish Health Survey data are available at Health Board level, with Edinburgh in Lothian and Inverness within the Highlands. As by far the largest cities in these regions, they will have heavily influenced the overall Health Board figures for these areas. These data are based on self-reporting and surveys are known to significantly under-estimate consumption. It is well documented that alcohol consumption is under-reported due to selective reporting, recall bias and accidental under-estimation (Boniface and Shelton, 2013, Bellis et al., 2009, Marcellus, 2007). A long time differential between pregnancy and the time of interview may lead to more unreliable data on alcohol consumption. Rates of alcohol consumption for women by The Scottish Health Survey estimated usual weekly alcohol consumption for 2008/09/10/11 combined. For Lothian 64% of women were moderate drinkers, 22% were classed as hazardous/harmful drinkers. For the Highlands 67% of women were classed as moderate drinkers, with 19% hazardous/harmful. The mean units a week also worked out at 8.5 and 7.8 respectively (A National Statistics Publication for Scotland, 2012). The population on 30<sup>th</sup> June 2010 was 310,830 for Highland, and 836,711 for Lothian, with a birth rate of 9.9 and 11.7 respectively.

### **3.7.2. Recruitment of women to the study**

Prior to entering the field, a pilot interview with a woman in Liverpool was conducted to test the methodology. This ensured that the researcher was able to test the appropriateness of the method for this research project. As the methodology utilises long periods of silence and minimal interviewer intervention, it was important that I trialled the methodology. The pilot also proved useful in highlighting subtle changes that could be made to the SQUIN and was useful in thinking about the structure of the different subsections that exist within the interview.

An important and essential feature of the sample was that it consisted of women, specifically mothers with children under the age of two. These criteria were purposive so that the respondents had a recent experience of pregnancy (under two years) and this would impact their narrative greatly. I chose a biographic narrative

method for my research and being a mother is a standardised point. I wanted to obtain from mothers their complete pregnancy history as well as an account of all previous experiences with alcohol. I was able to do this by examining from a life course perspective as previously argued narrative research is especially useful for this. Another rationale for choosing my sample was that I did not want to alter inadvertently women's behaviour or make them feel guilty or anxious about the health of their unborn baby. I was aware that a lot of women may inadvertently consume alcohol at a time before they realise that they are pregnant and I did not want to make them worry about the health of their child, the stress of which could be potentially harmful in itself. However I also wanted to use a life course perspective, and I recognised that there may be an interesting relationship with women and alcohol after they have had their child, such as during breastfeeding. Interviewing women with children under the age of two meant that they still had a relatively recent birth experience and were able to include this part of their narrative. I did however not exclude pregnant women from the sample and I did speak to two mothers who were pregnant at the time of interview; however these women had already had one or more children and consequently their current health and lifestyle behaviours were informed by their lay knowledge of their previous pregnancies. They also asked to be included in the study. By asking about the first memory or experience of alcohol each participant started their narratives at different times (e.g. they started their narrative at different ages) – not just at the start of their pregnancy (see SQUIN in Section 3.4). This allowed the women in this study to still concentrate a large part of their biography on their experiences of pregnancy, but ensured that the interview was from a life-course perspective, reflecting the role of alcohol in their lives as a whole.

I chose not to normally interview pregnant women for a variety of reasons, firstly, as they are designated a vulnerable group I did not want to cause any unnecessary strain or stress on women whilst they were still pregnant; however, this was also in part because I wanted to get the entire pregnancy story. If I were to interview women who were pregnant, they would not be able to account their entire experiences with alcohol during pregnancy, I would therefore also not gather any information on the role of alcohol at other times such as whilst breastfeeding. As this research is designed to look at alcohol consumption during pregnancy from the life-course

perspective it was useful to interview women who already had children as they could then discuss the role that alcohol plays in their life now that they have children. This also enabled women to tell their stories around alcohol consumption and breastfeeding. It was particularly interesting where women had had more than one child and were able to talk about the different experiences that they had between the pregnancies. I also recognised that it would be difficult to talk to a pregnant woman as access to these women may also be more difficult. A discussion of their experiences here may also change women's behaviour, and also may lead to women feeling anxious about the health of their unborn child.

The intention was to recruit a sample of women which would be equally spread across the two localities, in age and I wanted to keep the study as open and accessible as possible. It was also expected that some women would be recruited who had more than one child as this would be interesting to examine any differences in health and lifestyle changes that the women had made between different pregnancies. It was anticipated that the study was made as inclusive as possible and women's drinking status was not a criteria. It was originally hoped that a minimum sample size of 20 would be reached with 10 respondents from each locality; however 14 respondents were recruited from Edinburgh and 7 were recruited from Inverness giving a total number of 22 participants. Unfortunately, as indicated in Section 3.5 one participant from Inverness withdrew shortly after the research which left 21 participants within the study.

The recruitment of participants originally commenced via contact with mother and toddler groups throughout the chosen areas. The initial stage of this was advertisement to the mother and toddler group of the research project; this entailed sending the group a letter (see appendix 4) explaining the study and also flyers advertising the study (see appendix 5). After this initial contact, all mother and toddler groups were contacted by telephone to request permission for the researcher to attend the group and talk to members, giving the researcher an opportunity to answer any questions that the group had of the study. This stage was problematic as some mother and toddler groups proved hard to access by telephone, either the contact details provided were wrong, or in a few instances groups were held in local buildings such as church halls, libraries or town halls. This proved challenging as I was often reliant on other people to pass messages on. In some cases people were

reluctant to give out the contact details for the organiser of some mother and toddler groups. Some groups also did not want the researcher to attend. A number of the groups also clashed in the times that they ran, given that they were often in different areas, and travel limitations, accessing them both was also problematic. It was not possible for the interviewer to attend each mother and toddler group that was originally contacted by post. The groups that were visited by the researcher were influenced by the willingness of the group to receive the researcher and also the groups were chosen to ensure that different localities within the research areas were also visited.

Table 1: The number of groups that were contacted across the two sites, how many groups received a follow up telephone call and how many sites were visited by the researcher.

	Edinburgh	Inverness
Groups contacted by post	25	9
Groups contacted by telephone call	15	6
Groups visited by researcher	8	5
Total participants interviewed	14	7

At the mother and toddler groups, women who were identified as potential respondents were then given an information sheet (see appendix 2) which contained detailed information on the study and what it entailed. This also provided an opportunity to have a small discussion with the researcher giving further details on the study and for the researcher to answer any questions that the women had. It was made apparent to the participants that the interview was voluntary and confidentiality was assured. The contact details of the women who indicated that they were interested in participating were then taken and this was then followed up with a phone call to arrange a time and date for the interview that would be suitable to them. Several women showed interest instantly, revealing that they had stories to tell that may be of use, recruitment was therefore quite opportunistic and pragmatic. It was highly dependent upon the range of women at the mother and toddler groups

and took the form of modified snowballing. In speaking to the women in attendance it was evident that the majority of the women had never been asked to take part in research before and they appeared pleased, often implying that there was some gravitas and importance of being asked for your story for an interview. However some women were a little more apprehensive, articulating their fear that 'I'm not sure I will have much to say'. However because this research was about a potentially sensitive topic, 'stigmatising discourses and emotional defences may have contributed to the difficulty in recruiting research respondents and the content of the data elicited' (Harlow, 2009, p.213). This may also have resulted in women giving accounts which protect them from being othered or stigmatised (Lawler, 2002). Williams (1984, p.984) argues that 'because maternal substance use and FAS/FAE remain highly stigmatised, women's experiences of substance use, particularly during pregnancy, are often accompanied by intense feelings of guilt, shame, and trauma that can render women vulnerable in actions with researchers'

For the data collection in Inverness, very rural and remote areas were visited. This often made recruitment difficult as many women live far away from the services and potentially may rely on other forms of childcare and resources. As a consequence of this, at one mother and toddler group I attended, only 2 mothers attended. The women at this group revealed how they acted almost as a childcare community in bringing other children to the childcare. For one of these women, the journey to and from the mother and toddler group alone took nearly 40 minutes. She explained that with young children and other commitments, as well as other conditions such as the weather; in general attendance at some groups was fairly low. This also revealed to me that some mothers were quite isolated in Inverness and is one of the reasons why participation was lower in this city.

### **3.7.3. Location of interviews and the home as a research site**

Selecting an interview site can be a complicated decision, especially when the content of the interviews may be of a sensitive nature. There are clearly pragmatic considerations of the interview location in research, Elwood and Martin (2000) argue that most texts offering researchers advice around interviews encourage researchers to find convenient, quiet, easy to locate and private interview sites. The texts,

however, fail to offer guidance upon the social and political dynamics of the interview locations.

As Elwood and Martin (2000, p.649) argue, the interview site has a social and cultural context, the 'interview site itself embodies and constitutes multiple scales of spatial relations and meaning, which construct the power and positionality of participants in relation to the people, places and interactions discussed in the interview'. There are therefore ethical considerations of the interview location as research aims to be conducted within 'neutral' locations. Some interviewees may be reluctant to conduct an interview in a public place for example where they are at risk of speaking within ear shot of others. There therefore needs to be a consciousness on behalf of both the interviewer and respondent about confidentiality in the research site, as different power and spatial relations may alter the contribution that participants make to the research.

Choosing a location for interview is not just a matter of convenience and comfort (Herzog, 2005), it provides a space for the constitution of power relations (Elwood and Martin, 2000). Different spaces will therefore leave participants in different positions in regards to the power that they hold within the research process. Five of the interviews for this study were performed in coffee shops, the location of all interviews was left for the participant to decide, I always offered to meet them at whatever location was most convenient for them given that most of the mothers had small children who would be present. The selections of these spaces also may reveal the cultural importance of these spaces to the neighbourhood and the social geographies of the place (Elwood and Martin, 2000). By handing the choice of where to locate the interview to the women interviewed aligned with the consideration that this left the participants more empowered. However as Herzog (2005, p.29) purports 'the meaning of interview location does not, however, rest in the interviewees alone, rather, it is part of symbolic dialogue with interviewers, who themselves bring their own understandings of place to the interview'.

Giving participants a choice of interview location is conducive to improving the atmosphere for the research process and the sharing of personal information (Longhurst, 1996). The home is therefore a setting that provides intimacy, and enables emotional, sensitive or private issues to be dealt with (Herzog, 2005). Most



of the women who I interviewed for this project chose to be interviewed at home. I think this is partly influenced by the reality that most had small children, or babies, who were often with them, which would influence their travel arrangements, especially in Edinburgh where city centre residents may not have had access to their own car, and also in Inverness where there is perhaps not reliable and regular public transport available. This therefore solved the issue of childcare and meant that they could fit the interview around feeds or sleeps.

My experience during the interviews was similar to that of Herzog (2005, p.37) who found that 'the children were present in the home and wandered in and out during the interview'. This sometimes added a feeling of chaos to those interviews that were conducted within the home. In many of the interviews, children were present or were in other rooms in the family house. At times this meant that interviews had to be paused whilst nappies were changed or babies were breast-fed. It is questionable if this prevented women from reaching a true 'gestalt' as they always had to be keeping an eye on the baby. Also in a quarter of the interviews some children were keen on playing with the tape recorder during the interview or the participant's husband, when present, interrupted the interview at times. The gestalt 'is not a consciously constructed life narrative, nor is it an understanding of the place and use of narratives in social practice. Instead, it is a psychosocial subject, which is not consciously authored and cannot be articulated in conventional narrative form' (Mason, 2002, p.233). The gestalt as defined by Hollway (2000, p.34) is 'a whole which is more than the sum of its parts, an order or hidden agenda informing each person's life', therefore the gestalt gives shape of the story (Jones, 2004).

The interviewees were asked to choose where they would like to be interviewed and this resulted in the majority of interviews being conducted in a home setting (their own) or a setting which was familiar to them. By allowing the participant to set the location of the interview site, this helped to negate power relations between the interviewer and the participants by helping to remove a position of researcher as 'expert'. It also gave the women within the study comfort and convenience and also enables a stronger relationship to build between the researcher and participant. Three interviews were also conducted over the phone as this was most convenient. The use of telephone interviews was not as favourable to face-to-face interviewing as the non-verbal communication was lost, but the use of BNIM still allows for

biographical discussions and reflexivity and reflection by participants. The telephone interviews were only carried out due to the limited time frame of this research yet Jovchelovitch and Bauer (2000) argue that the method of narrative interview which may only rarely be accomplished. Frey (1983) argues that there is often a taken-for-granted assumption that participants will be reluctant to open-up to the researcher over the telephone or will resent the intrusion into the private spaces of the home. However I felt that participants were open with me in both interview scenarios.

The time limitations and other issues in working away from home meant that these three were interviewed by telephone. This was particularly apparent in Inverness, when women were not always available to be interviewed as they lived in very rural areas, with poor public transport systems. The limitations of phone interviews in comparison to face-to-face interviews are well documented as traditionally the telephone has not been seen as suited to qualitative interviewing. The method has a lack of rapport or visual cues (Rubin and Rubin, 2005, Gilham, 2005, Zelner et al., 2012) and is more difficult with the BNIM approach as body language could not be read. However as Chapple (1999) and Irvine et al. (2013) argue telephone interviews offer greater anonymity around sensitive topics. People are used to communicate by telephone (Irvine et al., 2013), and Holt (2010) used telephone interviews for narrative data collection as a preferred alternative to face-to-face interviews. Telephone interviewing also was a practical option geographically and lead to the greater availability of participants. For example, I was able to call once the children had been put to bed at a time most convenient for the participant. This created no embarrassment at having to rearrange face to face interviews, and meant that I caused minimal interruption to the chaotic and busy lives of the women interviewed. As argued by Walkerdine (1990) the use of telephone may also reduce the intensity of the 'surveillant other' by not invading the participants home.

Telephone interviews inevitably led to women breaking their narratives from time to time to check 'I was still there' and I had to make more utterances to show I was in fact still listening. This made the second sub-session slightly more difficult in cases where it was difficult to ask for more details and led to the negotiation of a different relationship with participants, than those who were interviewed face to face (Wengraf, 2001). These interviews were also recorded with the participant's permission and transcribed. Women had information and consent forms from the

initial contact and extras were sent to ensure that they retained a signed copy for future reference.

#### **3.7.4. Data collection and the structure of the interviews**

At each interview, confidentiality was reiterated and it was explained exactly how the data were going to be anonymised and used. There was a brief discussion of the format of the interview and the themes that I was specifically interested in. This was also used as an opportunity to go over the information sheet and the consent form that the participants were provided. This period also allowed the respondent to ask the researcher any other questions that they had. This phase of the interview was important as it also allowed the interviewer to develop a sense of a relationship with the participant, and it made the interview feel less formal. It was reiterated to the participant that I was interested in anything that they felt to be important and that they could talk for as long as they wanted to. This emphasised that the interview was an opportunity for them to tell ‘their story’, and explore things that had been important to them.

The SQUIN was asked and then sub-session one was undertaken. The majority of the women interviewed appeared to find the method easy; only one woman asked if I could “just ask her questions”. However some women did ask to see a general list of the things that I was interested about, just in case they felt that they got “stuck”. The interview technique allowed women to produce a narrative and therefore each interview was highly individual with interviews lasting an average of 45 minutes; the shortest being 23 minutes and the longest lasting 1 hour and 35 minutes. Although some of the interviews were short, the respondents in each interview had the responsibility for setting the agenda (other than the SQUIN) and therefore they had the control over length; it was the telephone interview which was by far the shortest interview. This could have been improved upon by perhaps conducting the third sub-session interview, however time and financial constraints within the research prevented this.

After the participant ended their narrative, questions were asked upon things that they had mentioned, these followed the order in which they had appeared in the narrative and at all times used the words that they had produced in their narrative. All participants were offered a break between sub-session one and sub-session two.

However, only a few women took this opportunity. Those that did so were mostly women in the home who wanted to check on their sleeping children. At the end of each interview, participants were asked if there was anything else that they would like to add, and this was a useful method for ensuring that the ending was not a 'fake' ending, and offered a good way of closing the interview. It was evident that the participants enjoyed taking part in this study, as it provided them with an opportunity to talk about their experiences of pregnancy. This period for reflection was accounted to be found to be enjoyable by some of the participants who welcomed feeling as though their stories 'counted'. At the end of the interview each respondent was asked to sign the consent form if they were happy with their narrative being used in the study. This was done afterwards as it was felt that the participants were more capable to consent to their narrative being used after they had produced it. Also several women were in contact with the researcher after the research interview had ended to report information they had forgotten which they thought might be important, similar occurrences were reported by Oakley (1981).

On the whole I felt that the interviews went well, the general tone used by the participant during the interviews was one of happiness and on reflection, many interviews contained laughter, and in some interviews jokes featured, or women shared 'in' jokes that they have with their friends, family or partner from when they were pregnant or from particular experiences. However within the majority of interviewees sadness was also a feature as women spoke of personal tragedies or hard times in their lives including but not limited to; miscarriage, death of a family member, alcoholism, cancer and post natal depression. In some interviews the participants cried and so did I. In most, laughs were commonplace and these were shared, I feel that all of this helped to break the interview/participant power dynamic, and ensure that the research was more feminist in nature. A main feature of all the interviews was the hospitality I was shown from the women involved. At nearly every interview I was offered tea, biscuits, cake or some lunch, within the interviews in cafes or coffee shops a few women when interviewed even insisted on buying me a coffee because I was a student. I concur with the writing of Undurraga (2012) in that I felt 'my appearance, approach, personality, voice intonation, overall manner and others' perception of me may have also contributed to gaining access and getting a good response from participants' (Undurraga, 2012, p.424). It is true that within

the interviews ‘something may ‘fail’ to be discussed because the topic or information is deemed irrelevant or lacks salience for the participants’ (Poland and Pederson, 1998, p.305). However I have assumed that the women interviewed have told me their stories and this was a truthful version, I considered their narrative to be valid and honest.

### ***Silences in research***

As Mazzei (2003) contends silences and pauses often occur within qualitative research and are a prominent feature within the biographic narrative research method. Nearly all the interviews carried out for this research featured some silences or long pauses. In thinking about these silences the question remains what do these silences come to represent and how as researchers can we interpret these silences? Kirkman (2008, p.303) argues that ‘silence signifies an absence-of words and / or perceivable emotions’, but what is the importance of these silences and what value do they bring to our research? An examination is given to silences within this research here, as in agreement with Poland and Pederson (1998) I believe, these silences are often overlooked. The question therefore exists, how do we consider these silences as part of our data collection? I think it is important that within qualitative research we consider that silences have meaning (Charmaz, 2002, Mazzei, 2003, Poland and Pederson, 1998, Lawler, 2002) and as Mazzei (2003, p.355) contends, do ‘not dismiss silence as an omission or absence of empirical materials but rather engage the silences as meaningful and purposeful’.

When examining silences amongst methodological literature, attention is more often given towards uneven power relations, how some people are silenced (Charmaz, 2002) or the ‘privileging of a normative position’ (Mazzei, 2003, p.358). However I think it is important that we consider these silences, as potential indicators of something being intentionally or unintentionally being omitted or representing the unspeakable, or the seemingly knowable where shared experience is assumed. This is especially true for this research study, as the interview discussions touched upon sensitive matters, for example, where an admission to consuming alcohol consumption during pregnancy may lead participants to feel they have failed as a ‘good’ mother and therefore feel stigmatised, or other highly emotive topics such as miscarriage or post natal depression.

Silences are often deliberate and can be laden with meaning, therefore, potentially they reveal the performative aspect of interviews and narratives and how we manage ourselves for different audiences (Charmaz, 2002). As Poland and Pederson (1998, p.294) argue, silence is ‘a cultural mode of self-presentation’. We therefore should ‘pay increased attention to silent subtexts, to what is being left out, not said, or intentionally repressed in our ongoing quest to discover the ‘truths’ within our spoken stories’ (Mazzei, 2003, p.356). We, therefore, cannot presume that because nothing is said that someone has nothing to say; in fact, what is not said may be as telling as what is, and might exceed what is put in (Poland and Pederson, 1998). Silences in this study may have represented the process of self censorship or a hesitancy to speak for fear of offending or being labelled or stigmatised, therefore, intentional silence exists as a form of resistance or withholding. However within this method as there were no real questions asked, just to elicit a narrative story, women were able to self-censor.

It is inevitable that some silences, or pauses, featured within the interview. These sometimes clearly highlighted moments where women reflected on what they had just said, were trying to remember a specific story, or also at times of sadness. Pauses and silences featured both on the part of the researcher and the participant as moments of reflexion. As in the psychoanalytic context, silences are laden with meaning and represent the space to reflect and grown within an exchange. I also need to consider the silences I, myself, added to the research. As a feature of the methodology, silence was used to help elicit more detail within the interview, being that silence can make us uncomfortable if we are not used to hearing it. Interview silences thus became a subtle ‘cue to elaborate further’ (Poland and Pederson, 1998, p.296) but also revealed active engagement on the behalf of the listener. Within the structure of the BNIM methodology there is restricted input on the behalf of the researcher. This builds on the idea that ‘there is something to be said for giving people time to reflect, ponder, and engage with you and with the subject matter at their own pace – namely being willing to wait’ (Poland and Pederson, 1998, p.296). This feature of the methodology that as a researcher whose natural response to something interesting is to follow it up with questions and probing, I had to fight to remain silent until the participant had given their full story before taking my turn to speak. My silences are therefore also a feature of the interviews. Instead I gave

supportive utterances to make sure it was evident that I was listening to what they were telling me, and to demonstrate that I felt their story was valid and of use.

False starts could be indicative that perhaps some of the story is not something that may have recounted or spoken about before, unlike the birth narrative which in general felt more rehearsed. It could be inferred from this that women talk less around their experiences of alcohol consumption whereas, in comparison, the birth story is likely to have been told and re-told to family, friends, and health professionals.

Sometimes silences, can be wrongly interpreted as ‘inaction, disinterest, or non-response’ (Mazzei, 2003, p.363). I am not demonstrating that every silence is possibly understandable but that we should give them as much consideration to them as we do to what is said, as Mazzei (2003, p.358) contends it is in those absences where ‘the very fat and rich information resides’. In conjuncture with these silences, I also argue that attention needs to be paid towards other – non-verbal cues and body movements. Body language during the interview process is as important as what is said, and also gives an indication of a participant’s willingness or comfortableness during the interview. It therefore reveals ‘the hidden, the covert, the inarticulate: the gaps within/outside the observable’ (Mazzei, 2003, p.358). Linked to silence is also body language. I paid attention to non-verbal communication, which is key within the BNIM methodology, as is voice intonation, pauses, reading between the lines and paying full attention towards each participant. Researchers must, therefore develop methods for listening (Devault, 1990) and I ensured that I made a note of this during each face-to-face interview.

All interviews were recorded on a digital voice recorder and then transcribed *verbatim* and an attempt was made to not clean up the transcripts. The process of doing this offered a rich introduction into the data (Devault, 1990). Ellipses have been used in transcription to show any deleted or un-clear speech, however because of the nature of the methodology there were very few interruptions to the narratives. Participants were asked if they would like to receive a copy of the transcript, and it was made clear that the participants were free to withdraw from the study at any time. The participants were asked if they would be happy to receive future contact possibly so that a third sub-session could be carried or if any questions occurred at a

later date. All participants received a card or an email thanking them for their time and generosity and wishing them well for the future.

When thinking about the ownership of the data ‘what a story means and whose story it becomes may change, when stories are research data’ (Charmaz, 2002, p.303). Data are co-constructed or co-produced, (Lawler, 2002, Mason, 2002, Buckner, 2005, Mishler, 1997) between researcher and the participant. Mason (2002, p.227) expounded that ‘the task is to work out how to organise the asking and the listening so as to create the best conditions for the construction of meaningful knowledge’. I am interested in what I am told, even if aspects of it may be fabricated. I am looking for the hidden meanings and inconsistencies, contradictory opinions present and listening to the silences within the research;

As social scientists, we start with research participants’ stories but we tell; them in another way. Which stories we tell, how we tell them, and how our audiences, including research participants, receive them all differ from the stories we heard. Sometimes we relate facts; often we provide fragments of stories, and, frequently, analytic stories

(Charmaz, 2002, p.318)

I hope that within this research I represent the women who chose to talk to me. I am sorry that all women are not completely represented as the wealth of information received could not be commented on within the confines of this thesis, and as already examined, because of the highly individual nature of the data collected, some women’s stories may appear more prominent.

### ***The participants***

The 21 participants who took part in the research are briefly described below (pseudonyms are used):

#### **Edinburgh:**

**Zoe**, aged 42 classifies herself as a light drinker. She is the full-time carer for her home and family lives at home with her husband and two daughters. She is of a Chinese background and is a Non-smoker.



**Rhea**, aged 35, works part-time as a midwife. She lives with her boyfriend and her eight month son and at the time of interview was trying to get pregnant again. She classifies herself as a light drinker, having started drinking when she was 15.

**Catriona** aged 29 lives with her husband and their nine month old son. She is a full-time carer for home and family; however is also currently a student in higher education.

**Neala**, 30 lives with husband and eight week daughter. She is self employed. She drinks alcohol and classifies herself as a light drinker.

**Wendy**, 33, lives with her six month son and husband. She works full-time as a teacher but is currently still on maternity leave.

**Florence**, 31 lives with her husband and their 13 month baby. She classifies herself as a moderate drinker and currently works part-time.

**Mya**, 21 is a full-time carer for her home and family. She lives with boyfriend and son. She classifies herself as a moderate drinker having drunk since she was 18 and has also been smoking moderately on and off for the past 5 years.

**Olivia**, 32, works full-time as a nurse, and lives with her husband and daughter. She is a light drinker and smokes occasionally.

**Elsie**, 42, works full-time as a physiotherapist. She lives with her five month old daughter and her husband. She classifies herself as a light drinker, and remembers first trying alcohol when she was 7. Elsie referred to herself as having issues with alcohol and a very poor relationship with it, her father was also an alcoholic.

**Jennifer**, 20 works full-time, and previous to her pregnancy was working two jobs. She lives with her boyfriend and their 14 week son, and describes herself as a light drinker.

**Paige**, 28 works full-time within a council but is currently on maternity leave, she lives with her husband and newborn son. She classifies herself as a light drinker.

**Tina**, 32 works part-time in Schools and lives with her boyfriend and their two month old son. Tina was pregnant with her second child at the time the interview was conducted. She classifies herself as a light drinker.

**Yvette**, 35 - 44, is a full-time worker in the pharmaceutical industry. She lives with her husband and 6 month old daughter. She classifies herself as a light drinker. (please note Yvette provided an age range).

**Imogen**, 32, is a full-time carer for home and family. She lives with her husband and 2 and a half month old son. She doesn't drink, describing herself as pretty much tee total because she doesn't really react very well with alcohol. She also is a non-smoker.

**Inverness:**

**Kylah**, 25, is a single mother who lives with her 7 year old son and her one and a half month old daughter. At the time of interview she was pregnant with her third child. She classifies herself as a light drinker and a light smoker, smoking 5-10 cigarettes a day.

**Leah**, 39, is an architect but is currently a full-time carer for home and family. She is planning to return to her career when her children are at school. She has two sons one aged three years old and the other was two months at the time of the interview. She is a light drinker.

**Rachael**, 32, Lives at home with her husband and is a full-time carer for home and five year old son and two month old son, previously having worked in a call centre. She is a Light drinker, however reported previously having a problem with alcohol in her first marriage.

**Victoria**, is a single mother with a son aged thirteen, a sixteen year old daughter and baby daughter. She doesn't drink and doesn't allow alcohol in the house after her previous partner was abusive when drunk.

**Eilidh**, 35, is currently a full-time carer for home and for her partner along with three daughters, aged 13, 10 and one and a half. She categorises herself as a light drinker and a light smoker, smoking on average 8 cigarettes a day. She grew up with her family working in pubs.

**Skyla**, 42, works part-time. She lives with her husband and two daughters, oldest aged 3. She classifies herself as a moderate drinker.

**Hermione**, 37, works part-time and lives with her husband and two month old daughter. She classifies herself as a light drinker although rarely drinks. She started smoking at the age of 15 and used to smoke 1.5 packs a day, and quite a few times, the last being about 3 years ago.

### **3.7.5. Reflections on the research**

As Pearson (1993, p.vii) examines: ‘published accounts of fieldwork are invariably cleansed of the ‘private’ goings-on between researcher and researched’. I however aim to reflect upon the research highlighting these ‘private’ issues and matters that I faced as a researcher for example; my methodological stance, political issues, access to the field and my experiences of data collection.

I am aware that my presence and positionality as a researcher may have affected some people’s accounts, leading to possible under-reporting of some issues and exaggeration of others; however I feel by using the BNIM and having minimal intervention as the researcher I have minimised this. Narratives are co-authored since they are all to some degree co-constructed between the participant and the researcher (Jones, 2004, Bolton et al., 2005). I was aware of the role of the researcher in the collection of narratives since any probing questions that I used could potentially influence the data collected, as it may direct the participant in their answers. The BNIM approach minimised this due to the very low level of interviewer intervention. Each participant was only steered towards the themes of the study, however it was made clear that I was interested in the individual experiences of each participant and what they thought was important to them. Eliciting stories depends on asking the right questions and I followed the interview protocol ensuring that all SQUINs asked in sub-session two were based on themes that the participant had already mentioned, and I always used the participants own words for these. In this respect, no themes were discussed about which the participant had not chosen to talk openly.

It needs to be noted that a narrative is reproduced for a specific audience. In this case this is a research project and this may, therefore, influence the stories given. I recognised that when using the narrative as a research method where there is a lack of interviewer interventions and direct questioning and some participants did not talk about what I was interested in specifically. In this respect a theme which emerged as important in one interview was not always touched upon in a following interview

with another participant. This reveals how all interviews are highly individual reflecting how the narrative was produced naturally, and was not constructed under pressure from me. It has been noted that it can be difficult for some participants to leave their history 'behind'; this can result in parts of the narrative being side-tracked or on a 'tangent'. By looking at life stories in this way; women are able as individuals to prioritise what was important to them in their story and therefore this may mean that certain aspects are missed out. However this forms the basis for why narrative was chosen as the method of enquiry as it allows an understanding of alcohol in aspects to women's lives. Narrative is a human centred approach: it is structured by normative/shared experiences.

I feel that the use of BNIM and its limited interviewer interventions, limited this power differential as it gave the participant power over what was discussed during the research process. I, as the researcher, ultimately chose whose quotes to use, whose stories to tell. Yet the narratives of the women who participated each highlighted different themes, with different emphasis because of the nature of the data and its reliance upon the individual experience. If I was to concentrate on one of the other themes that is evident from the data I have which space here would not allow, voices from other women in the study may become more prominent. I therefore have to accept my responsibility and the power I had within the research. The data analysis and conclusions of this research are all shaped by my positionality.

I also tried to negate the power differentials through the avoidance of taking a position as 'expert' during the research process. In fact the opposite became true; my positionality made the women interviewed the experts in motherhood, pregnancy and childcare. As a single, white, English childless woman, I felt that the participants within the study were happy to share their experiences with me and at all times I identified myself as a researcher (Gillham, 2005) and made my social status as a doctoral student clear. All participants were aware I was not a mother, as most women asked this either on first meeting at the mother and toddler groups or during general conversation at the time of the interview. The women were inquisitive to know if I had a child and if I would be able to relate to them on this level. I do not think that being childless hindered me in my research; instead I would suggest the opposite, as it led to the participants feeling like educators. The women interviewed had existing knowledge and experience into something that I did not know about and

therefore sometimes I felt like they were enlightening me in the process of becoming a mother and what I should expect for the future. I would argue that the women interviewed were more open to talk about issues such as alcohol consumption during pregnancy with me because of this. In this respect their experiences were not affected by any worry that I may have had a different experience or different belief on some matter relating to pregnancy and motherhood i.e. choices around breastfeeding.

I was therefore a young woman they could teach or tell important information to, or things to look out for if I get pregnant or have a baby; or informed of things that the women had wished people had told them when they were pregnant. The participants therefore shared experiences with me both within and outside of the interview that they thought were important to be told or to be learnt from. This included experiences with midwives, health visitors and breastfeeding support groups as well as breastfeeding issues and labour. As a childless woman who has not ruled out the idea of having children at a later stage in my life, they had something to tell and effectively teach me about what the experience of pregnancy was really like, what labour actually entailed, for example how it was worth all the pain in the end. I also endeavoured to treat each participant afresh, listening to their story as if it was the first that I had heard, that they might have something new to be told (Gillham, 2005). I had no prior knowledge of what I would be told in each interview; with this narrative method women produced their own individual stories so each story was, therefore, new to me.

I recruited women for this study from mother and toddler groups. Some of my data collection coincided with the news headline that a nursery nurse within the UK had been abusing children. Some women were therefore very reluctant to talk to me, a stranger at the group. However, at the same time I was wonderfully welcomed by some mothers who were always keen to introduce me to other mothers in the group or other people that they knew who they thought might be interested in the study.

Other issues that had to be dealt with in the construction of my methodology were that I was an English researcher from Liverpool and I had to conduct my research within Scotland, this therefore presented time limitations but also meant that I had no background within these communities in the field. I was as a result robbed of

physical and social context and had never previously had any face to face contact with anyone in these communities. Researchers in this context face limited options, so to negotiate this I spent time in Scotland and after initial contact via telephone and through posting information sheets, I went and made personal contact with the mother and toddler groups from which I recruited. The interview became a reciprocal process (Undurraga, 2012). When asked for my experiences or life history, it was given. For example, some participants wondered why I was from Liverpool and what had made me interested in this issue in Scotland. Investigating the participant's life experiences, we must realise that completing this interview is also part of their life experience now and my own as researcher (Presser, 2005). I felt that I could not expect these women to be open to me about their experiences if I was myself not also willing to share my story.

This is not a gender neutral topic that I am studying. Some feminist theory such as the work of Finch (1984) and Oakley (1981) advises that women who interview women should be from the same position. The work of Stanley (1990), Skeggs (2005) and Stanley and Wise (1990) also touches upon this subject but deals more about class sensitivity. To be from the same position would imply that perhaps the interviews would have been better suited for a mother to carry out. However I would oppose this view and argue that, as a childless woman, the participant was not threatened by my birth account as I don't have one. There were therefore no contradictory views or experiences between myself and the participant. Instead, as previously argued, the participants seemed to want to teach me their experiences of childbirth and motherhood to prepare me for me possibly undergoing it in the future. Most women indeed asked if I intended having children in the future and I was given the opportunity to learn what 'real' motherhood and pregnancy entails, 'what the books don't teach you'. This aligns with the work of Fonow (1991), Grosz (1994), Lawler (2000), Maynard (1994), Oakley (1993), Rogers (2006) and Wolf (1996) who also provide similar feminist reflections.

It was evident that this research method suited some women over others as some women found it easier to talk for long periods of time and account their story, whereas some women struggled a little at first with getting used to the interview method, and one participant did ask if I could just ask her some questions. I did then

ask her a few questions but after this the participant seemed to follow the BNIM method and provided narrative.

I have tried here to reflect on the research process, as other feminist writers have (Waterson, 2000b, Oakley, 1981). I am extremely grateful to all the women who gave their time to participate in this research. As Oakley (1981, p.43) describes 'I was asking a great deal from these women in the way of time, co-operation and hospitality at a stage in their lives where they had every reason to exclude strangers altogether'. I have been honest about the limitations of this research with reflection on the part of the researcher, highlighting my sensitivity to the inherent power structure of the interview process.

From my experience with research into women's alcohol consumption during pregnancy I now have a heightened awareness of how agenda has to be negotiated in research. It is clear that within any research it is to a point co-constructed between the participant and the researcher. A different methodology would have inevitably changed women's responses in some way; closed questioning would have led to women talking about alcohol. However it would not have shown how choices that women made around alcohol were influenced by other social and cultural factors in the women's lives.

Because I was working alone, away from home various safety issues had to be negotiated and I set up a safety procedure for each interview. The experience that I had from this fieldwork has enabled me to become more skilled at locating myself at different positions in the field.

One issue that further needs to be reflected upon was the fact that this research is sponsored by the Scottish Government and the ESRC. This affiliation was made clear to each participant and I am sure for some women this acted as a way of legitimising and giving the research credibility. However, I recognise that it may also have put some people off taking part as they did not want to disclose information because of political issues. I think possibly some women thought that the research was government controlled and this put them off being interviewed.

### **3.8. THE DATA ANALYSIS AND ANALYTICAL METHOD USED**

It is acknowledged that the process of transcription forms part of the analytic process and this process, although timely, allowed for an increased familiarity with the data set. Through this process an early analysis was born, allowing for re-occurring themes to be distinguished. Narrative interviews require interpretation and different approaches of narrative analysis were examined for suitability. This assessment of the variety of different ways in which communication could be examined led to a long consideration for the different analytical approaches that would be best used. It was decided that narrative analysis would be conducted, and that a combined method of thematic analysis and structural analysis would give the most rigorous results.

A thematic analysis allows for a further understanding and a more detailed picture of the context of a transcript, therefore examining the ‘what’ and ‘why’ aspect of a narrative. The exclusive focus of this type of analysis is on the content of the narrative examining in detail what is said. The main perceived benefit of using a narrative thematic approach is that it allows for the finding of common thematic elements across a number of transcripts and differing experiences. For an example of thematic narrative, the work of Williams (1984) and the illness narrative was examined. This method of analysis was suited to this study as it concentrates upon the meaning behind the stories given, and it was thought that this would therefore be useful for examining women’s experience of alcohol consumption, their understandings and how these impacted their decisions around alcohol consumption during pregnancy.

On the other hand a structural analysis emphasises the way a story is told, focussing on the form, organisation or structure of the narrative. This close examination into language has been recognised as a highly useful method of narrative analysis, with many researchers adopting it ‘to notice how a narrator uses form and language to achieve particular effects’ (Riessman, 2008, p.81). It therefore examines the function behind an analysis and goes deeper than a thematic analysis would to examine what is being portrayed by the participant, revealing what they think is the most important aspect of their stories, giving attention to personal meanings through detailed consideration to narrative form and lexical choices (Reissman 1989)



Examining the way in which a story is put together is useful for examining the meaning behind it and its use yields different findings than observed with a thematic analysis (Riessman, 2008). This examination into the form of the narrative allows 'topics and voices to be included in qualitative research that might be missing otherwise' (Riessman, 2008, p.80). The structural model proposed by Labov and Waletzky is one of the most recognisable and widely used analytical perspectives examining the structure of narratives. Labov and Waletzky (1997) maintain that narratives contain six elements which are used by the participant to construct and make sense of the story: the abstract, the orientation, the complicating action, the evaluation, the resolution and the coda. On closer inspection of this mode of analysis proposed by (Labov and Waletzky, 1997), I feel it is too inflexible for my data in that it is more suitable for shorter stories, rather than a narrative that may not be completely temporally or chronologically ordered. However elements of their analysis may be useful, for example the evaluation which 'conveys to an audience how they are to understand the meaning of the events that constitute the narrative' (Elliott, 2005, p.9) is something that would be important to analyse. Its limitations as a model for analysis have been recognised and it has been identified as un-suitable for life history interviews. It is, instead more suitable as a method for examining shorter, more bounded stories. Some of the data collected for this study would fit into what Elliott (2005, p.46) examines as material which 'has a story-like form but does not strictly consist of a sequence of event clauses' and 'often include a whole set of different narratives' within the interview. The benefits of using this approach for shorter narratives are well founded. However, I did not recognise it to be the best form of analysis for my data which quite often contained multiple stories and were not always chronologically ordered.

The approach to transcription used by Delanty (2005) based on units of discourse is defined as an 'ethnopoetic structural approach which is suitable for lengthy narratives that do not take the classic temporal story form' (Riessman, 2004, p.2). This method of analysis requires attention to subtlety, focussing on how the narrative is spoken. It organises the narrative into idea units, stanzas and strophes based on the way in which the narrative is spoken and therefore effectively examines the relationship between the form of the narrative and the meaning conveyed within it. Great detail is paid towards the linguistic devices used by the participant to convey

their story such as differences in pitch, tone and false starts use of metaphor, and repetition. These are more easily examined through the process of breaking the text up into these small parts. As developed by Delanty (2005, p.36) 'narratives can have a global organisation even when they are not being repeated from memory as stored wholes, even when the narrator does not necessarily know in advance where she is going and where she is going to end up'. This process of analysis leads to 'intensification and evocation of meaning' (Ohlen, 2003, p.565) as it is argued that fundamental meanings that are evident within the structure and form of a narrative are lost when this form of telling is ignored (Kitchin and Tate, 2000).

Its benefits as a research method for 'analysing extended narratives of experience' (Riessman, 2008, p.93) are well acknowledged and it is practical for narratives where the text is not clearly bounded or is in part organised topically rather than temporally. This method of analysis suits the data collected for this research more than the method proposed by Labov and Waletzky (1997) because of the ways in which some of the narratives collected are very long and contain multiple stories. 'Because structural approaches require examination of syntactic and prosodic features of talk, they are not suitable for large numbers, but they can be very useful for detailed case studies and comparison of several narrative accounts' (Riessman, 2004, p.2). After an examination into the way in which Jones (2004) used an adaptation of Delanty (2005) as a way to look beyond the content of speech, it was decided that the linguistic features of the data would be examined using a structural analysis loosely based on the work of Delanty (2005). A thematic analysis will also be undertaken to help convey the experience of women and the meanings behind these and the roles it played in their decision making process.

After the interview had been transcribed verbatim, the recording was listened to again and double checked with the transcript. For a selection of the interviews where interesting thematic themes had emerged, the text was re-transcribed paying close attention to changes in pitch and false starts. Pitch falls and rises were concentrated upon which were then sorted into a more hierarchical structure based on the work of Delanty (2005) into idea units (one piece of new information generally marked by 'and' or another conjunction), lines (made up of one or more idea units) and then these were formed into stanzas (often four lines long, and normally sound as if they

go together). As Riessman (2004, p.14) explains: ‘stanzas sometimes show intricate structure and patterning, taking on some of the properties of stanzas in poetry’.

The pitch glide as defined by Delanty (2005) forms the focus of the sentence and ‘each stanza is a particular ‘take’ on a character, action, event, claim, or piece of information, and each involves a shift of focal participants, focal events, or a change in the time or framing of events from the proceeding stanza. Each stanza represents a particular perspective, not in the sense of who is doing the seeing, but in terms of what is seen’ (Delanty, 2005, p.13). Delanty (2005) argues that stanzas appear relatively short, and generally each line within the stanza is the same length, and I found that in general this pattern was followed within the transcription.

The transcription technique is an adaptation of the technique used by Delanty (2005) and Riessman (2004) and for this process of analysis I have subtly cleaned up the transcript by excluding some of the interviewer from these transcripts for ease of reading purposes only. However, because of the use of BNIM there were minimal back chatter utterances or interruptions by the interviewer which needed to be removed. All interviews were fully transcribed verbatim but after initial analysis some sections of interviews that had been highlighted as important were then further analysed and then reformatted into this style. For some transcripts the whole interview (both sub-session one and sub-session two) has been re-structured in this way. For some transcripts only the opening narrative (sub-session one) has been transcribed. Dividing the text up into stanzas was straightforward yet a time consuming task. Initially it was hard to distinguish some stanzas. However lines seemed to fall into patterns of two or fours and when, there was an extra line, on analysis it appeared that this was usually a coda to the stanza, and acted as a way of participant reflection on the topic or even that had been discussed. This central meaning is reminiscent of what Labov (1972) termed the evaluation within a narrative.

There appears to be a somewhat poetic layout to the transcripts using units of discourse and it is evident that ‘it is possible to produce a transcript which preserves some of the rhythm and structure which characterises speech’ (Elliott, 2005, p.55). However some careful decisions have to be made as to how much transcription detail is necessary for this method of analysis. The use of this loose interpretation of the

units of discourse (Delanty, 2005, Riessman, 2004) aims to assist in finding patterns within the narrative that reinforce thematic themes already identified. By combining a thematic and a structural analysis, I will be able to examine broad patterns within meanings for individuals but also the variety between them will be unearthed. I do not want to 'decontextualise narratives by ignoring historical, interactional, and institutional factors' (Riessman, 2004, p.2). It is important that a thematic analysis is also retained. I will therefore use these different modes of analysis to reinforce each other to therefore strengthen my analysis.

### **3.9. ETHICAL PROCEDURES AND POSITIONALITY**

As with any research, it is important that the potential impact of the research on those involved is considered. All research therefore requires an acknowledgment of the ethical issues that are present. This research followed the ethical guidelines and codes set out by the ESRC and The University of Liverpool. An ethical application was submitted to the University of Liverpool Research Ethics Committee and approved. NHS ethics was not sought due to the timeframe for the data collection; University of Liverpool ethics was granted and this enabled the field work and data collection to begin as early as possible. The fieldwork for this thesis began in June 2009 with interviews in Edinburgh occurring and interviews with women in Inverness were completed in October 2009. Despite having received ethical approval for the study, it is important to consider that this is not the conclusion of the ethics process within this research project, as with any research, ethical consideration continued at all times throughout the research process.

The ethical features of confidentiality, anonymity and security were used within this research. Throughout the research, the principle of informed consent was used. Participants were not coerced to take part and it was made clear to them at all times what the research entailed. Participants were therefore able to make an informed decision before participating in the study. It was explained to participants that confidentiality was of a high importance to the researcher and the process of this was explained in full. Interviews require complete anonymity of all participants and effort has been made to ensure the protection of the identity of all participants with the use of pseudonyms throughout this thesis. I have attempted to make the new name assigned a Scottish name where I could. However this was not possible for

every name and so for other names I pulled names out of the most popular names in Scotland. All participants were given an information sheet and signed a consent form (see Appendix 1 and 2). It was made clear to all participants that they are able to withdraw from the research at any time. It was also made clear to participants that if they disclose any criminal activity a third party may be informed. A process of line management was used in case any issues that the researcher is uncomfortable with discussing were mentioned. As the mother and toddler groups were voluntary community groups within an informal setting, disclosure control was completed through academic supervisors.

I followed the ethical standards of positionality and was sensitive to the differences between myself, as researcher and the women interviewed as participants within my research. I was attentive to ethical issues throughout the study, including during data collection, with an awareness that things can be unpredictable and cannot be foreseen. As Adams (2008, p.179) describes: ‘working with ethics involves realizing that we do not know how others will respond to and/or interpret our work. It’s acknowledging that we can never definitively know who we harm or help with our communicative practices’. As Duncan et al. (2009) stress it is impossible to make predictions about responses that the participant may have so it is important to be ethically mindful of the challenges which research, especially qualitative research presents. I was surprised at my emotive reactions towards some women’s stories, stories of loss or battles with post-natal depression or abusive partners. Ethics continues throughout the data collection as ‘researchers are required to make decisions throughout the research process regarding what is ethically appropriate to enquire about’ (Duncan et al., 2009, p.1694). This is true as the respondents may have voiced accounts which previously had not been shared with many people, revisiting these experiences could quite clearly be painful for women, but at all times I treated the women with respect and symphonised with them. Yet Rosenthal (2004) argues that at times the interview can take on a therapeutic opportunity as research touches on these intimate issues. I cannot pretend that some of my participants may have neglected to tell me something that they are ashamed of (Josselson, 1996); however I can say that the women I interview went into great detail about many of their experiences, which all were of course deeply personal. This just further

demonstrates how ethically challenging research is, and how the ethics process goes beyond the mere act of signing consent forms or getting ethical approval.

Ethical thinking also influences not only how the data were collected, but stored, analysed and used. Once transcribed, the interview data were stored on a secure server to which only I have access. To be truly ethical, this chapter has shared the dilemmas which I faced in the research process, what Duncan et al. (2009, p.1692) title, 'the untidy stories of qualitative research'. As a research method, BNIM was highly useful and I feel it allowed me to get some rich data. With any research it is inevitable that problems may need to be negotiated (Roberts, 1990), yet it is important that these ethical and methodological issues are acknowledged.

### **3.10. CONCLUSION**

This chapter has outlined the theory behind this research and the methodology employed to collect data for this study. Utilising a feminist methodology, the biographical narrative interviews were especially useful in allowing the women interviewed to tell their story. This worked to remove power from the research process (Oakley, 1981, Wolf, 1996) and gave the participants an open space to tell their story. This methodology was also undertaken because of some of the sensitive aspects of the research. The research methodology aligns with my interest in gender and power differentials, giving space for an understanding of the issues which effect women personally. I have utilised a feminist perspective to therefore ensure that the methodology did not render the participants powerless and as much as possible gave the control of the research process to them. Women were not only given the space to talk about their experiences but it was evident that they reflected on their experiences and how becoming a mother had transformed them. The use of a life course approach enabled women to identify how their experiences as a youth impacted upon their current choices around alcohol. When given the opportunity to discuss their stories and experiences at length, with limited guidance or interruption from the interviewer, it was apparent that many of the women interviewed talked at length about their pregnancy and especially the birth narrative. This is perhaps because elements of these narratives will have been told and re-told, for example, the birth narrative may be something that women had have shared or at mother and toddler groups and it was evident that this was a much more coherent, temporal space of

events, compared to other parts of the narrative that did not ‘flow’ so well. Themes identified from the analysis are explored in greater detail throughout the rest of this thesis.

## **Chapter 4. The Importance of Lay Knowledge, Inconsistent Messages, and Othering**

### **4.1. INTRODUCTION**

One of the key aims of this research is to explore women's attitudes towards alcohol during pregnancy and their outlook towards existing public health campaigns. Holloway et al. (2008) argue that an examination is needed into the disparity between the somewhat well-publicised drinking guidelines and reported individual drinking practices. This is particularly true for women's alcohol consumption during pregnancy, if we are to understand further why some women may not follow the recommendations that are given to them. This chapter examines the inconsistency of messages which women receive about alcohol consumption during pregnancy, revealing that not only is it important for them to be given messages of abstinence during pregnancy but that the manner of how these messages were given to them influenced their take up. In particular this chapter examines the response of the women who reported getting the abstinence messages, highlighting their reactions to the guidance and the emerging tensions of a 'one size fits all' policy. I will then examine the way in which this led women to challenge the notion of harm and the evidence base behind the guidance, leading to a lack of confidence in the medical profession and an increasing reliance on lay health beliefs, including an assessment of the importance of intergenerational messages. Finally the chapter draws upon how this advice also relates to other health behaviours demonstrating how this is a complex subject matter and that this is indicative of the way in which women's accounts interwove.

### **4.2. WHAT ARE THE HEALTH MESSAGES GIVEN TO THE WOMEN BY HEALTH PROFESSIONALS?**

As previously indicated in Chapter 2, there is no consensus as to whether there is a safe level of alcohol consumption during pregnancy (Ethen et al., 2009, O'Leary and Bower, 2011) and there has been widespread and ongoing concern about the impacts that the consumption of alcohol during pregnancy may have on the unborn foetus. There is insufficient evidence to show that there are significant effects of low to moderate alcohol consumption, adding to the considerable debate on the relationship



between alcohol consumption and harm (Plant, 1984). It is evident that the women in the study were aware of a general discourse that they should abstain from or cut down alcohol during pregnancy.

#### **4.2.1 Inconsistencies of messages and how the ensuing confusion undermines the message for abstinence**

The study revealed that the majority of women interviewed had received a message regarding their alcohol consumption during pregnancy. Of those who did not explicitly state that they received one, they still made reference to being aware that alcohol consumption should be limited during pregnancy. However the narratives of these women highlighted the conflicting messages which women receive. These inconsistent messages bear influence on how women perceive the advice and for some women lead to a belief that there is a lack of scientific evidence behind the new recommendations for abstinence. This finding concurred with the media articles by Geddes (2012), Mosley (2013) and Scotsman (2008a) that revealed that messages given to women around alcohol were often conflicting. It became evident from listening to the women's stories that inconsistent messages on alcohol consumption in pregnancy had become more prominent in recent years due to the change in recommendation towards abstinence in Scotland. The women's stories frequently highlighted the unclear and often contradictory advice that they received. Catriona, a first time mother, emphasised this lack of transparency in the guidelines stating;

I think the advice for whether you are allowed one glass or two glasses of wine is very blurred...that came out in the middle of my pregnancy that statement, which just confused everything even more

Catriona, 29, Edinburgh

Despite finding the advice unclear, Catriona implies that the consumption of alcohol, specifically wine, is still tolerable during pregnancy. However, she is still unsure on the amount of wine she can safely consume. It was evident across the narratives of the women interviewed that the inconsistency in message clearly had implications on the recommendation of abstinence as women internalised the inconsistent messages. Zoe highlights the inconsistent messages women receive; and the ensuing confusion that coincides with these.

You know it's funny how, erm yeah, okay a lot of people say you should cut down or stop because it, erm it will have an effect on the well-being of the baby, erm the foetus, but I have heard doctors, or you always hear, doctors' in France saying red wine is good, you know, iron source

Zoe, 42, Edinburgh

Zoe reveals how she received messages to cut down or stop; however these messages contrasted with her awareness from the medical profession of the benefits of red wine. Zoe was not the only women to receive inconsistent messages. Over half of the women interviewed pointed out the recommendations that they received were inconsistent. This lack of consistency only served to confuse women to what the safe drinking practices during pregnancy are, as predicted by Plant (2008). The new recommendation for abstinence evidently seemed to exacerbate this confusion and it was apparent that this was frustrating for the participants who were trying to do the best for their baby. Just over half of the women in this study reported receiving inconsistent messages regarding how much alcohol was safe to consume during pregnancy from their doctor, Rachael recalled receiving advice that went against the recommendation for abstinence:

When I was first found out I was pregnant with Kai, I actually had a discussion with the doctor and he said that it doesn't actually harm the baby if you have a glass of wine with your meal, or erm if you have, you know, the odd glass of wine here or there, you know it's not going to make any difference

Rachael, 32, Inverness

This statement reveals that in some instances doctors are reluctant to tell women to abstain completely from alcohol consumption during pregnancy, if perhaps they see no grounds for it. In Rachael's case, the doctor expressed a confidence that there was no harm caused to the baby from the low consumption of alcohol during pregnancy, and that consequently it would be reasonable for her to consume alcohol at a low level. These messages undermine the recommendation for abstinence, and adhere to the scientific evidence which suggests that only binge drinking during pregnancy is harmful, and no evidence reveals light drinking is problematic (Kelly et al., 2009,

2010, Knupfer, 1991). Yvette's experiences mirrored this inconsistency of message as she exclaimed:

Some doctors were saying "oh there's no difference", and some were saying "oh you shouldn't be drinking at all if you're trying to conceive"

Yvette, 35-44, Edinburgh

It became evident that these inconsistencies in messages, especially from the doctor serve to hinder women in their decision making capability with regards to consuming alcohol during pregnancy. As I will indicate later (see Section 4.3) these inconsistent messages serve to encourage women further to possibly consume small amounts of alcohol during pregnancy. Yvette was also one of only a number of women in this study who picked up on the message that you should abstain from alcohol even if you are trying to conceive. Despite revealing that she received inconsistent messages, Yvette highlighted an underlying perception that medical guidelines should be followed and that it is important to know what the recommendations are. Her experiences highlighted the inconsistent messages that the women in the study received, even from the health professionals and how these inconsistencies undermined the message for abstinence.

#### **4.2.2. Official versus unofficial advice – the importance in the manner of delivery of message, not just what was said but how it was said**

The inconsistency across messages meant that the women sometimes separated recommendations into that of official advice versus practical advice. Paige demonstrated how her midwife told her that she shouldn't drink during pregnancy; however this advice was given in a way in which it was to be interpreted that although this was the official advice, it didn't need to be strictly followed:

The midwives official advice, I remember her saying that, she would tell me that you're not meant to drink anything at all, erm but she kind of say it in a way that you understood that although that's the governments guidelines its said like, so people's ideas of drinking are completely different

Paige, 28, Edinburgh

It is evident that an awareness of the inconsistencies in message only reinforced to Paige that it is probably safe to drink a small amount of alcohol. The midwife in this circumstance has told Paige of the medical discourse to abstain but recommended that in her situation that she would be okay to drink. This suggests that in some cases, messages are being adapted for individuals and therefore an issue of underlying trust exists, which Paige's choices reflect. As a point of practice the midwife has told Paige that she should avoid alcohol consumption during pregnancy, however it is notable through Paige's recollection of this event that it was not what she was told, but how she was told it, that influenced her decision to consume alcohol most. Rightly or wrongly, this is the way she interpreted that conversation. This reveals the point that it is not only important what messages are given to women but also how they are said. The manner in which the message was given was important in how it was interpreted. Jennifer also recalled the advice she was given to be vague and not 'proper', again highlighting the importance of how messages are given to women:

I just sort of listened to what he had to say and I tried to put into perspective what he was saying, that you would be allowed you know every week if I was pregnant, putting that into perspective and erm in the respect of how much I had drank probably in that period of three nights out, but I never ever remember him giving me proper advice

Jennifer, 20, Edinburgh

Tina was another mother who also highlighted the inconsistencies in messages women received regarding a safe level of alcohol consumption during pregnancy. She visited the doctor worrying about when she had consumed alcohol before she knew she was pregnant. However the doctor reassured her that in her experience 'everyone' drank before they were aware of being pregnant.

The doctor was really reassuring and said that that happened, everybody has some alcohol before they realise that they're pregnant, and it's fine, its only when your drinking loads of wine, loads of alcohol every week or whatever that there is going to be a problem

Tina, 32, Edinburgh

This advice given in this situation is against the advice to abstain, as the doctor purports a view again that light alcohol consumption in pregnancy is not associated with harm. This situation is important, given that the advice is now to abstain before conception, and highlights the dilemma women are now in, due to the introduction of the advice for abstinence when they drank before they knew they were pregnant. The process of othering appeared as a theme across the women's discourses surrounding alcohol consumption during pregnancy. Tina's alcohol consumption was compared to the 'other' women who did drink loads of wine whose alcohol consumption is problematic in pregnancy. 'Othering' other women towards the recommendation became apparent across the women's narratives, as the women viewed the target audience for the recommendation for abstinence as women who drink large amounts of alcohol or who suffer from problematic drinking. The moral judgements that women make of their drinking and that of other women are therefore important (Tolvaven and Jylhä, 2005) when we examine women's alcohol consumption during pregnancy.

Some of the women in this study choose to continue to consume alcohol during their pregnancy; a justification given for this was that several participants did not feel that the guidance for abstinence was directed at them, mainly since they did not identify themselves as 'problematic drinkers'. In this case the theme of othering was serving to categorise certain segments of the population as 'unruly' (Thompson and Kumar, 2011) and therefore as an attempt to (re)draw boundaries between 'us' and 'them' (Valentine, 1996). The doctor in this case was aware that the recommendation to abstain does not take into account individual preferences and the pleasure that women gain from consuming alcohol, and also that some women may drink responsibly. The doctor gave reassurance that, although she had drunk before she was aware of her pregnancy, her baby would not be harmed. In such cases these messages around alcohol have been tailored to individual women, thus women are given practical advice that follows the belief that women should probably abstain but to drink a small amount of alcohol is not harmful. This view aligns with the medical evidence behind women's alcohol consumption during pregnancy that there is no evidence of harm from light consumption (Kelly et al., 2009, 2010, Knupfer, 1991). Some women reported getting the recommendation to abstain from their GP

(General Practitioner) but they did not feel that the advice they were given was robust, as Jennifer examines:

He just said you're allowed so many units, if it comes back that you are definitely pregnant you just have to be careful from then, erm I can't remember him ever really giving me any strong advice just telling me how many units I'm allowed to drink if I choose, if I wanted to do that but so, I can't ever remember his exact answer to that

Jennifer, 20, Edinburgh

Jennifer recalled getting advice to abstain from her GP, however it was not 'strong'; she therefore presents another example of the importance of the way in which women are given messages, not just what messages that they are given. Billingham (2011) asserts that health professionals are valued by parents as a trusted source of advice and information. In this case the advice that they have received has been confusing and contradictory, this could lead to a lack of trust as parents look elsewhere for sources to learn from, thus having an increased dependence on lay knowledge. Women receive different types of advice from different people and advice from official and unofficial sources. The research suggests that there appears to be these two distinct types of advice, and that confusion surrounds women's choices around alcohol consumption. This also highlights the way in which people resist the guidance for abstinence, and contradict it by advocating a small amount of alcohol is okay. This confusion is contributed to, in part, by the medical surveillance over women's bodies but also adds to the growing confusion that women face. The problem with government advice on abstinence is that such advice assumes a representative or commonality between women; however it does not consider for example, alcohol dependencies/history, class or knowledge. Instead we need to recognise the importance of these differences.

#### **4.3. WOMEN'S REACTIONS TO THE INCONSISTENT MESSAGES WHICH THEY RECEIVE**

##### **4.3.1. The problem of a 'one size fits all' health policy and 'other' women**

Approximately one third of participants' accounts reflected a keen desire to form their own opinions about what constituted a safe level of alcohol consumption during

pregnancy; for these women, individual choice was of a high importance in their decisions around health behaviours. These women looked for a clear reasoning behind the health messages to abstain and instead received conflicting messages. This influenced them as they did not see their low level drinking as putting the health of their unborn child at risk. Instead they sought to take control over their own bodies by making their own decisions (see quote from Yvette on page 143 and further discussion in Chapter 6 and 7 of pleasure and the feminisation of wine) based on lay knowledge (for a broader discussion of the finding of the importance of lay knowledge see Section 4.4). Viewing the message to abstain as being too simplistic and being a policy which assumes that 'one size fits all' was a factor across three of the women's accounts. This 'one size fits all' approach to health promotion appears to be based on stereotypes of gendered behaviour (Coles et al., 2010). Yvette argued that this one size fits all guidance is not realistic, attainable or achievable. In her view it is not useful as she explained:

But it just seems so much of the national health is just that one policy fits all and that is just not realistic for the way people are... I think information about alcohol during pregnancy and during breastfeeding is pretty rubbish, because again it's like one policy fits all and now they just say to people don't drink anything

Yvette, 35-44, Edinburgh

Yvette clearly objected to being coerced into a particular behaviour, for her this was being told she had to abstain from alcohol during pregnancy. She evidently felt the message was one size fits all and therefore was not appropriate to her. Across their accounts it was apparent that some women, Yvette included, are asking for a less patronising approach to these health recommendations. The findings revealed how women want sufficient information on the subject to enable them to make up their own minds, within the context of their own lives. This is indicative of the argument of Davison et al. (1992) that simplistic or patronising information that glosses over complexities is likely to be rejected to be people. For these women the one size fits all policies failed to recognise the individual differences. It was clear that some participants resisted the one size fits nature of the new guidance; women wanted recognition that all women are different and have a different relationship with

alcohol. The women therefore resisted the recommendation because it was not aimed at them, they aligned with the belief that health is the responsibility of the individual (Waterson, 2000b) revealing the importance of being able to make their own choices.

It is therefore important that recommendations are in place to help individuals to make up their own minds and recognise the different definitions of risk; women are therefore seeking credible information on the risk and an attention to individual differences. The one size fits all and inconsistent messages which women felt were aimed at 'other' women were deemed not suitable. It was clear that independent choice was strongly linked to a sense of empowerment and responsibility. It is important to consider how exercising choice in defining one's own health risks which Waterson (2000b) argues has been ignored.

I think now they're kind of not willing mothers to make these decisions for themselves, so they're kind of making them for them in a way erm (pause) but then I think it probably is quite a good thing

Paige, 28, Edinburgh

Paige indicated an idea that this one size fits all was flawed as specific advice should be set for different women, depending on their drinking habits. As these participants interpret their drinking as positive, they do not feel targeted by the recommendations. The recommendations, thus do not speak to them. The problem may therefore lie within the nature of the communication by which the recommendation is given. Women potentially see it as 'policing' and controlling their lives (Ettorre, 1997) and there is a perception that women are thus being told what to do. It is therefore evident that there still exists what Waterson (2000b, p.172) describes as a 'stumbling block' in the way in which health promotion guidance is presented. The recommendation for abstinence is seen to be a policy which is one size fits all; however it therefore does not incorporate difference, some women therefore see the promotion of abstinence as unwelcome (Waterson, 2000b) as they interpret these messages to not be aimed at them, and their health behaviours are therefore challenging the medical power by resisting the guidance.

In this approach, the messages given to women to abstain from alcohol during pregnancy reveal the control that is apparent over women's relationship to alcohol



(Ettorre, 1997). Being told what to do, opposes the idea that women should be able to make their own choices. This lack of choice is in opposition to the ‘your baby, your way’ type of advice or the health model of choice. This conflict and how it mirrors the internal conflict that women face of doing things for themselves versus doing things in the interest of their baby is important, especially that increasing medicalisation of motherhood sees the women being reduced to the ‘maternal environment’ (Rothman, 2000, p.112) for the foetus. This highlights the on-going power struggles within the pregnant body (Jones and Chandler, 2007). Some of the women were clearly unsure about these messages, as they resisted being told what to do on an individual level, yet they recognised that for some other women it was important to be told what health choices to make.

### ***Othering***

In general, there is an awareness that women should avoid alcohol during pregnancy, or at least cut down. However it is apparent that some women do ‘other’ themselves to this advice feeling that it is aimed at ‘other’ women, who perhaps have poor relationships with alcohol. Some women reported drinking alcohol at very low levels and therefore did not report drinking alcohol during pregnancy at a level at which there is evidence of harm. Holloway et al. (2008) argues that ignorance towards recommended drinking levels could be indicative of a lack of concern about the health consequences of drinking. However the women, who consumed alcohol in this study, did so in awareness of the conflicting medical discourses around women’s alcohol consumption during pregnancy. They clearly felt that the recommendation for abstinence simply wasn’t aimed at them, or other ‘light’ drinkers. The women who chose to consume alcohol were not ignorant of the advice, they were still clear that it was important that they reduce their alcohol consumption during pregnancy, aware that heavy drinking is probably harmful. Sometimes their knowledge was incomplete, or unclear because of the conflicting and inconsistent discourses, but they were still aware that some guidance did exist.

A generalised feeling was asserted that the advice to abstain is only applicable to ‘drunks’, binge drinkers or heavy drinkers. Therefore, the women who only drink at low levels, felt that the advice is not aimed at them and they do not feel obliged to follow it. These women are not drinking large amounts; instead their consumption

remains at levels which adhere to what the recommendation around alcohol consumption during pregnancy was previously. It is important that attention is given to the role of othering within self governance and lay health choices. In several cases women within the study insisted that because they interpreted their drinking as 'normal' it was consequently not harmful. Their opinion was that the recommendation was therefore not targeted at them but instead at 'other' women, as Skyla demonstrates:

The reason that was given to us was by the health people, advised against drinking in the first trimester really, and keeping it very limited after that. I think this time they are saying not to avoid it all together, but I got through one pregnancy with a little bit of wine, err my feeling is that is aimed at people who are excessive drinkers

Skyla, 42, Inverness

This extract offers an appropriate example of how women interpreted the government recommendation for abstinence to be targeted at other women who drank excessively during their pregnancies, therefore consequently feeling they were exempt from following it. Skyla distinguishes herself as not an 'excessive drinker' and because of this does not feel the advice is aimed at her; again she reflects the importance of her own lay experience, although being advised to abstain, she reflects upon her behaviour from previous pregnancies where she drank and does therefore not see a reason to change her behaviour for her current pregnancy. Although aware that the advice is now to abstain from alcohol, she maintains that this is aimed only at 'excessive drinkers'. Skyla reported generally restraining from alcohol consumption during pregnancy (except "a little bit of wine") because of the perceived unknown risk that drinking a large amount may pose to the health of her unborn child. Her narrative was greatly informed by the notion of risk because of previous miscarriages and ectopic pregnancies. It was these traumatic experiences which resulted in her wanting to look after her body and fearing the potential risks that consuming alcohol might bring; despite this she was certain that a small amount of wine would not be harmful. By demonstrating self control over their alcohol consumption during pregnancy, women including Skyla protect their moral identities (Rolfe et al., 2009) and prevent a stigmatised identity. They therefore protect their

moral status as a 'good' mother and prevent themselves from being perceived as bad or irresponsible mothers.

This othering may exist because the women interviewed didn't feel there was a reason behind the change to the recommendation for abstinence (see Section 4.3.2) as these messages are aimed at 'other' types of women who drink heavily during pregnancy. This is also influenced through the type of alcohol drunk, for example there was less perceived harm from drinking red wine, compared to say cider, vodka, whisky or other spirits consumed more by 'real' alcoholics in the public's mind. There is also a class implication of this with wine perceived more middle class and therefore safe (see Section chapter 7 for a further discussion around the importance of the type of alcohol).

Women who believed that they were sensible with their alcohol consumption, perceived themselves and other women who drink at low levels to not be the target audience for the advice to abstain. Yvette recognises the difference in what drinking means for other women by maintaining it is the 'other' mother who is irresponsible because they "don't think about" their alcohol consumption. As Yvette highlights:

I mean basically I drank practically nothing through my pregnancy, which certainly didn't do any harm. So I suppose that's the way I looked at it, when you're having a big family celebration and a glass or half a glass of champagne you don't want to feel guilty about something like that...I suppose the problem is that if some people don't think about it and I suppose moderate drinking for some is totally drinking than moderate drinking for others

Yvette, 35-44, Edinburgh

In this instance, Yvette, does not see herself as the target audience for the abstinence guideline. Instead she feels that the advice to abstain is aimed at women who are moderate or heavy drinkers. This is no surprise as it is often a certain group of women who are often vilified in the media for their alcohol consumption. For example; young women have also been targeted for binge drinking and the associated unprotected sex leading to unwanted pregnancy (Naimi et al., 2003, Foster and Marriott, 2006, Kanny et al., 2013, Mallard et al., 2013). Yvette

recognises the difficulty in constructing policy which addresses these health messages, when drinking levels and the definition of 'moderate drinking' is highly individualised.

Yvette, therefore, uses the process of othering as defined by Plant et al. (2002, p.332) to 'project the unacceptable face of women's drinking onto other (frequently younger) women, leaving their own identities unspoiled' by reassuring herself that the messages for abstinence are not meant for her. This has strong links to the literature on 'good' mothering (May, 2008, Duncan, 2005, Kirkman, 2008, Lawler, 2000, Letherby, 1999, Lupton and Fenwick, 2001, Miller, 2005, Oakley, 1979, Radcliffe, 2011a, Rothman, 2000) as women resist being criticised for their health decisions by comparing their choice to those of other women. Some women expressed that they were aware their choices were different to others and were individualised choices, different to their friends or family. Women that therefore continued to drink during pregnancy showed awareness that by deciding to drink during pregnancy they were resisting these normalised ideas of how a pregnant woman should behave (i.e. to not drink). There was therefore an element of tension evident as women noted that their choices may be different to expectations of them and the perceived implications that this may have for them as women, to be a 'good' mother. It is also evident that individualization, which emphasizes personal responsibility for life outcomes, is dominant in late modern societies. Many people appear to have accepted that they should make themselves aware of risks and therefore act in accordance with the experts' risk (Lupton, 1999a). Rhea felt that the message for abstinence had been instated because of concerns over 'other' women, who are uneducated about alcohol and consequently who drink too much.

It was just that, erm, I think there were concerns about women knowing what one or two units was and women drinking too much

Rhea, 35, Edinburgh

Emphasis is placed here by Rhea on women who were uneducated and did not understand units or what is safe to drink. There is a link here to class in that these women who drink must be uneducated and that is why the guidance had to be changed. Paige also demonstrated the theme of othering. Even as a midwife herself, she communicated her belief that the recommendation to abstain is not aimed at

women similar to her but to other women whose idea of what drinking is not the same as hers. There is the assumption therefore that these messages of abstinence are only aimed at very heavy drinkers or alcoholics.

So my idea of drinking one glass of wine can be someone else's idea of a bottle of wine or whatever, so I think it was very much that you can have a little bit in moderation but it wasn't really recommended

Paige, 28, Edinburgh

The midwife in this situation assumes that Paige's understanding of what is meant by moderation is also similar to hers, and that she will in general only drink a very small amount of alcohol. Picking up again on the lexical choice use of 'little bit' and 'moderation', and 'wasn't really recommended' reinforces the different perceptions around alcohol consumption that exist. Paige does not refer to the midwife expanding on what moderation during pregnancy means, or what "a little bit" is understood to represent. Instead these are presumed common understandings that women share, this utilises the work of Geertz (1983) and understandings of 'common sense' in that there is no such things as 'common sense' instead that it is a learnt idea. A "relatively organized body of considered thought, rather than just what anyone clothed and in his right mind knows" (Geertz, 1983, p.75). The midwife's idea of common sense may therefore be different to that of Paige. Unless you have a firm discussion with women about how much they are drinking advice could therefore be misleading, and could potentially lead to women adopting their own decision and believing that they are 'above' the recommendations. Added to this there is also the continual problem of misunderstanding what a unit is (Kerr and Stockwell, 2012) (see Chapter 2 for a further discussion of the problem with a unit as a measurement). The unofficial advice is championed through the importance that women give to lay health beliefs and others' experiences. Women therefore felt that they are given the advice, yet left alone to make their own decisions about what line of action is best for them to follow. It is however problematic that women receive these inconsistent messages as it draws on the themes of responsibility and othering. The midwife therefore gives Paige official and unofficial advice and assumes that Paige will drink responsibly.

In talking of their alcohol consumption during pregnancy, it was apparent that some women had to justify their drinking as being safe, and responsible. This created what Rolfe et al. (2009, p.332) describe as a 'balancing act' as women compare themselves to other women. Controlled forms of drinking are acceptable, contrasted against other women's drinking practices which are more disorderly. As a midwife, this quote also demonstrates the lack of trust that some health care professionals have in the messages that they themselves are expected to give out. Paige resists these overarching messages that are being given to women which she feels have no medical grounding, as she reveals an understanding that women's ideas of drinking are varied, and that what is recommended is not always followed. Paige knew her drinking was limited; however she is aware that for some women, one glass of wine might be a much larger amount of alcohol. This has strong links to how alcohol measurements are understood which is important given the increased consumption of alcohol in private spaces such as the home as evidenced through increases of off-sales of alcohol (for a further discussion of drinking in the home during pregnancy see Section 5.3). Jennifer also had a strong sense that it was 'other' women who drank during pregnancy by positioning her own relationship with alcohol in opposition to these women seeing it as a personal, individual decision and that this behaviour was often linked to dependency:

I just, I just never ever felt the need to (drink alcohol), like I didn't depend on it

Jennifer, 20, Edinburgh

Jennifer hints that she found little pleasure in drinking, and it is evident that didn't drink since she did not feel like she needed to; it was something that she could go without. Her language here recognises that there are some women who do depend on alcohol and that for them, the choice around drinking during pregnancy would be different to her decision-making process. In this thought, Jennifer is contrasting herself to 'other' women who need to drink during pregnancy, with the sense that unless you are dependent upon alcohol you should be able to abstain from it during pregnancy. Othering and its role in self governance became apparent as women demonstrated a perceived need for self control in identity protection. This control is,

therefore, the responsibility of the individual and as Rolfe et al. (2009) argues, forms part of a wider project of self-surveillance.

### ***Other Health Behaviours and Othering***

This notion of othering existed not just over alcohol consumption during pregnancy but also within other moral discourses which could see women judged. Women also demonstrated taking part in surveillance and judgement over other mothers. Mya demonstrated this in her narrative around smoking:

I don't smoke a lot, just five or six a day and it's usually if Lee is sleeping or before Lee gets up. Or if I out with the buggy I never smoke. I think there's nothing worse than seeing someone walking along the road with a buggy with a fag in their hand (laughs)

Mya, 21, Edinburgh

Although Mya was a smoker herself, she revealed that she would never smoke whilst pushing a buggy. She was aware that this was a behaviour which she would potentially be stigmatised for, and would lead to people making negative judgements of her as a mother for doing so. She actively participates in this othering as she herself judges mothers who do push their buggy whilst smoking, as she had strong moral ideas about smoking around children. She partook in the surveillance of mothers and judged them by their behaviours; Olivia also did this when watching mothers feed their children junk food in the park:

So it's quite worrying, you see so many fat children these days and it's like horrendous, every time I'm down the swing park there's like these little kids and they're all really, really chubby, and they just standing round the swing park eating tubes of Pringles after school and before their tea, and it's really quite scary. It's really your responsibility as a parent to make sure that they don't end up as a candidate for heart disease at ten years old.

Olivia, 32, Edinburgh

These quotes reveal the way in which people judge other mothers, the women involved were aware that drinking during pregnancy could lead to their being

stigmatised like other women. The ‘good’ mother was linked to a range of things not just alcohol, and it is these other ‘bad’ mothers who do not follow health advice or look after their children’s health, who are negatively judged.

#### **4.3.2. Criticism of the message - Challenging the notion of harm and evidence base and the claims that these messages were too simple and patronising**

Participants alluded to a general belief that there is a lack of research behind the recommendation to abstain from alcohol during pregnancy. Yvette questions the message arguing that it was simplistic, not justified and challenges the message of harm base. Yvette clearly demonstrated frustration with the messages given to women:

If someone gives me a rule and a reason there’s got to be a reason for it, and I find it very frustrating that you get these simplistic, right you’re not going to drink anything, the policy is that women shouldn’t drink anything at all because, that they you know, where you are, it’s not a really reasonable or sensible or way to speak to people, and if you really shouldn’t drink anything at all then I’m quite happy not to drink anything at all, but with no rationale and being told to sort of judge the situation yourself, what can you do

Yvette, 35-44, Edinburgh

Yvette illustrates that with no rationale behind the guidance you are left as a mother to “judge the situation yourself” lay knowledge was therefore very important. Resistance to the mixed messages that women receive is evident as they are critical of them. Instead of taking ‘no’ at face value, it is clear to see that women want to fully understand the reason behind it before adapting their behaviour to one of abstinence. Crucially, it was evident that the women who consumed alcohol during pregnancy did so not because of lack of knowledge of the guidance; they showed an awareness of the recommendations, but instead made an individual choice not to follow them. These women, therefore, were not uninformed or unaware of the advice that they should abstain from alcohol; instead they questioned, contested and resisted it. Women therefore made individual choices around their alcohol consumption, and these were highly influenced by their lay knowledge including their prior



experiences around alcohol from when they were younger and that of the parents or peers. Paige questioned the general acceptance of the advice, and from her narrative it was clear that she resisted the idea that there was a set policy that should be 'one size fits all'. Paige recognised that all women are different and have a different relationship with alcohol, so to therefore assume that all women are going to drink a large amount of alcohol is inaccurate. Women interviewed also criticised the messages for being too simplistic and patronising but did show an appreciation of the difficulties in setting public health messages in general. As Rhea maintained:

So I think they decided that for the simplicity of a public health message that they decided to say don't have any at all...and err its I think it's, really quite a patronising message, but I, but maybe, maybe, maybe it is wise. It's difficult with public health campaigns getting a simple message across that's not too patronising, but then not too complicated to understand

Rhea, 35, Edinburgh

Rhea highlights what she sees as the struggle in setting a public health message around alcohol consumption during pregnancy. She notes how messages aimed at the whole population can come across as patronising, but that perhaps this was needed in order to produce an understandable message. Although Rhea recognises that messages need to be simple, she made it evident that she didn't feel it was suitable, instead that it was just very vague and generalised. Although women resisted the guidance, some did however, recognise the difficulty that is involved in setting public health messages, especially given a situation where heavy or episodic drinking could result in foetal harm. This was also evident in the narrative of Neala who gave her own critique of difficulty in setting public health messages. The constant change in advice has led Neala to challenge the recommendation for abstinence and question how strong the evidence is behind the message to abstain:

There's always been lots of, new research and things that you see and it's all right to drink, oh it's not all right to drink, it's all right to drink, oh it's not all right to drink, it kept changing

Neala, 30, Edinburgh

For Neala, this frequent change in message has made following the guidance a hindrance. The lack of consistency in the message has evidently also led to a lack of trust in the message. The change to a recommendation for abstinence has led women to question why the previous advice which had been that a small amount of alcohol would be safe was incorrect, therefore questioning the reason for the change in recommendation. This has clearly left some women unsure as to what advice to follow, leading to women feeling indecisive and less trusting of medical recommendations. Tina also described this frequent change:

They change their mind every five minutes but now I think they are advising nothing at all, but for they were saying two glasses or three or something, I can't remember

Tina, 32, Edinburgh

From the participants' perspective it was evident there was an overwhelming feeling that the advice given to them is blurred as women receive inconsistent and contradictory messages about what they should do in regards to alcohol consumption during pregnancy. Lack of consistency has led to women failing to remember what the advice even is. Tina is clearly critical of the recommendation for abstinence, highlighting the inconvenience that it changes 'every five minutes'. Because of this, she is dismissive of the advice and demonstrates a lack of trust in it. The constant switching between messages and different findings in the media, (Scotsman, 2008a, Barnes, 2012, Geddes, 2012, Johnson, 2007, Moran, 2007, Mosley, 2013, O'Reilly, 2010, Parry, 2007, Rose, 2007) therefore lead to challenges of the robustness of the advice and then ultimately leads women to be less trusting of it.

In their narratives, almost all women demonstrated a willingness to accept guidance and health recommendations, if they are backed up by scientific evidence, prompting the idea that what they are being told to do does not always correlates with what is best for them. Other women clearly felt that not enough is known. Women were not just accepting the advice, and instead actively sought information, not just from the medical profession, but also from a range of other sources such as books, online articles and peers. Women's notions of responsibility and quest to ensure that they were 'good' mothers lead them to actively search for knowledge to enable them to

make their own choice. For Rhea, a clinically qualified midwife; further evidence is, therefore, required to back up the guidelines for abstinence.

That is why I decided because I have read quite a lot about alcohol consumption in pregnancy over the years, because I am actually also a midwife and so I have kind of kept up to date with what the advice is and what the evidence is and that's what I've decided to

Rhea, 35, Edinburgh

These women were doubtful of the scientific evidence behind the guidance and complained that the advice they were given was insufficiently accurate or detailed. Jennifer highlights the conflicting discourses around drinking during pregnancy, comparing advice she had been given to an inert feeling that drinking was something she should not do:

So I mean they did say to you, like you can have so many glasses of wine or so many units a week and I just chose, I didn't, I didn't see the point in having a drink when I knew that I probably shouldn't... I just never ever felt the need to, like I didn't depend on it

Jennifer, 20, Edinburgh

Despite being advised that alcohol could be consumed, Jennifer made her choice through an incorporation of the idea that drinking was something she perhaps shouldn't do, and it was behaviour that she could potentially be judged negatively for doing. The reference to the voices giving her these recommendations 'you can' versus 'probably shouldn't' implies a notion of risk and an awareness of what women should or shouldn't do; however it is apparent that within the study the women's own lay health beliefs were important in their decision making and their choice to consume alcohol during pregnancy or abstain. Women therefore contested and resisted the advice as they thought that the new guideline was not backed up by scientific enquiry, as Paige highlighted her belief that:

Yeah I think the only research that has been is that if you binge drink heavily then that can have erm an effect on your baby, but I would have

said that was quite obvious anyway.

Paige, 28, Edinburgh

The women that contested the guidance revealed that their choice was affected by an underlying assumption that the guidelines produced by the DoH were not backed up through scientific inquiry. Women therefore challenged the evidence behind the recommendation for abstinence and questioned the effect that alcohol had upon the health of the unborn child. This is unsurprising given that the evidence behind the recommendation or evidence of harm from low level of consumption is uncertain. They did not accept the recommendation at face value, and instead searched online for supporting evidence and to see the effects that consuming a small amount of alcohol would have. They therefore questioned medical evidence and lay health (Crawford, 2006). Time was therefore spent researching the effects of alcohol during pregnancy to ensure that they had sufficient knowledge on which to base their decisions. Some of the participants were therefore suspicious of absolutes and the idea that they should abstain completely during pregnancy. This furthered the idea that drinking low levels of alcohol was acceptable and this was especially true when women had previously drunk small quantities of alcohol and had a healthy baby. The recommendation for abstinence is therefore contested because women cannot see a clear reasoning behind it and feel that this is influenced through guesswork rather than any scientific notion of risk or harm. How can we therefore expect women to follow messages with certainty when we are unsure ourselves over the credibility of the messages and what the harm is? Rhea's narrative demonstrated that she questioned the medical guidance that was given to her regarding alcohol consumption, rather than accepting it at face value:

I know the advice used to be until I think before I was pregnant they changed it to you shouldn't drink alcohol at all and before that it was, it was that it was probably safe to have one to two units a week, erm and as far as I'm aware there isn't any evidence, erm that came to light to say actually women shouldn't be drinking at all [later] But I'm (laughs) but I'm not really sure what I think about that I mean, I think, I don't think that that you should you should have to give up alcohol, I think there's no

evidence to say that its dangerous in very small quantities, which is what I had

Rhea, 35, Edinburgh

Rhea questions and resists the guidance given to women, because she sees herself as being able to recognise how much she is drinking; she shows an awareness of units and suggests that there is no evidence to say it is dangerous in small quantities. She sees herself as a responsible drinker and queries whether the recommendations are backed up by substantial medical evidence. Rhea, looks for evidence behind the recommendations given to her, and uses her own health beliefs and experience to make her own mind and therefore demonstrates her 'expert body of knowledge' that she has developed (Popay and Williams, 1996, p.760). Her experience and circumstances led her to develop her own lay body of knowledge which, although different to that of professionals is, in itself, seen as an authority. For women, like Rhea, who did not believe that this recommendation was built upon significant medical verification that alcohol is harmful. The messages given to pregnant women are questioned and sometimes disregarded. A few women remained ambivalent to the advice because of this confusion and were not keen to trust it without further knowledge of the effects of alcohol consumption. At a time where women are already facing a lot of changes and different stresses and strains, it is evident that some women are not happy to blindly follow advice without questioning it first.

It is apparent therefore that the participants wanted to be informed of the risks that alcohol consumption during pregnancy can bring, rather than be told that they should abstain, a measure which they see as not backed up through scientific inquiry. They therefore wished to be informed of the risks rather than being told to stop drinking altogether (Ettorre, 1997). Through the participants' accounts, there was a clear feeling that the evidence behind the guideline for abstinence is not strong enough. Women seemed to reject the idea of abstinence as it negated any idea of choice and did not appear to have a strong medical grounding. Women therefore requested to be given scientific evidence to justify health recommendations, rather than health messages which seem to be based upon moral judgements (Ettorre, 1997). The women that contested the guidance revealed that their choice was affected by an underlying assumption that the guidelines produced by the Department of Health

were not well backed up through scientific inquiry. The women within this study are looking for recommendations given to them to be backed up; they scrutinise the messages that they are given and do not simply accept that this is what they should do, instead they want to know why they should do it.

This was not restricted to advice surrounding alcohol; anytime women worried or questioned the medical advice given to them, they actively searched for medical information that justified the recommendation; they questioned it and looked for resources online to support their decision making, challenging medical recommendations rather than taking them at face value. Catriona described how she actively sought evidence for health recommendations whilst pregnant:

I do think it's really important, erm to make sure that you know, they have the best food really and from the evidence that I could find from looking at things on line and from all the health professionals telling you that, I think I'm more inclined to try and find out for myself, or for my own accord why people are saying things

Catriona, 29, Edinburgh

It is evident that women are not naively accepting what they are told. Women clearly want what is best for their baby, but are not willing to follow advice for the sake of it. Women demonstrated that they were actions as 'good' mothers by doing the right thing. Women clearly want a reason for any health behaviour which they must follow, and question the credibility of health messages that are given to them. Women, who, therefore, resisted the recommendation for abstinence, did so because they want a reason for having to stop consuming alcohol during pregnancy. This is not necessarily because this is a health behaviour which they wish to desperately continue but is also influenced by the way in which women sought individual power over their bodies instead of being controlled and told what to do in every aspect of their pregnancies by an unknown source.

#### **4.3.3. Women's scrutiny of the messages they were given and their lack of confidence in the medical profession led them to question the source of the advice or "who" gives it?**

Of the participants who recalled receiving inconsistent messages around alcohol consumption during pregnancy, over half were critical of the messages given to them around alcohol consumption, revealing a lack of confidence in the medical profession. Are women therefore in Scotland becoming less accepting of the medical profession or health education efforts or is it that they do not see medical guidance as the be all and end all? The importance of lay knowledge and carrying out their own research was important to these women, as I have argued they resisted overarching simplistic messages and quite often did not feel that these messages were aimed at them, instead that they were targeting 'other' heavy drinkers. The inconsistency in message also led women to report having a lack of trust in the sources they are receiving messages from, therefore upholding the argument of Plant (2008, p.174) that 'the UK appears to be in some confusion over the best advice to give'. As well as contesting the evidence, it is apparent that women furthermore contested and questioned 'who' is setting the advice. Although, receiving guidance from a midwife around the consumption of alcohol in pregnancy, Skyla described it as only 'advice', indicating that it was not a rule that should be followed:

At the time, I was aware of the advice, the advice that you were advised by the midwife was not to drink alcohol,

Skyla, 42, Inverness

The guidance was therefore a suggestion, something which women were able to avoid if it wasn't aimed at them and the common theme across some of the interviews was the way in which participants, made reference to an elusive "they" or "who" who gave the advice. This theme is strongly linked to the themes of power and surveillance as developed by Foucault (1979), as women appear to be more resistant to instruction when they do not know who is setting these messages. There are clearly different discourses of power that are evident linked to the theory of the medicalisation of pregnancy which sees the mother and child as two separate patients, additionally treating reproduction as a medical condition in need of management that views women as no more than foetal containers (Annas, 1986,

Purdy, 1990, Ruddick, 2007a) and that these containers must be free from the pollution of alcohol (Ettorre and Kingdon, 2010, Murphy and Rosenbaum, 1994). Women actively question what power the bodies have to set this advice and this is also exacerbated by the way in which women question if they are they right in setting this advice. This reveals that women are unconvinced by these messages. Paige was also aware of the change in guidance but she does not indicate who in particular was setting or giving out this advice, instead she referred to the body as “they”:

In terms of current health campaigns I know that they're very keen to stress that no alcohol should be consumed during pregnancy

Paige, 28, Edinburgh

The women in the study, who spoke about receiving messages around alcohol consumption during pregnancy, were often aware of a sense of authority in these messages but were often unsure as to who the body is that is setting it. This is evident as Catriona actively questions the authority that sets the advice:

Even the advice, I think that is set by, whoever gives out this kind of advice. I can't remember who or what sort of authority says that you mustn't drink in pregnancy anymore.

Catriona, 29, Edinburgh

How women are resisting the power that is placed upon them through medical discourses and biopower is evident in Catriona's interview which revealed the ways in which women challenge and dispute the authoritative recommendations set to pregnant women. The use of “authority” by Catriona infers that the advice has some power and influence behind it, contrastingly the use of “whoever” and because she couldn't recall who gave her this message affected Catriona's response to the messages around alcohol consumption during pregnancy. She not only questions the advice that women receive, but also questions what organisation sets the advice and the power/rights that they have to appoint it. It was clear therefore that women want to know who is setting the advice, and therefore who is telling them what to do. Women therefore rejected a disciplinarian message which did not take into account their discretion. Such comments reveal both their awareness of messages and a sense



of responsibility but this questioning also indicates that women are suspicious of where messages come from, often resulting in their questioning the advice, and its credence. Contrastingly Paige revealed a consideration that perhaps some women need these strong messages, and likens this medical intervention during pregnancy to the messages around smoking:

I think related to kind of drinking in pregnancy, the government and kind of, medical profession is very keen to make you stop smoking during pregnancy as well... I think that's probably the trouble with alcohol during pregnancy, that not enough is known about it, so people need to air on the side of caution an awful lot. I think maybe in America where my friend was coming from, I think maybe it's more kind of highlighted there about the potential harm that alcohol, alcohol can do to your baby erm and we are only just starting to go that way ourselves

Paige, 28, Edinburgh

Again there is an expectation that because "not enough" is known about alcohol in pregnancy risk is therefore uncharted, but that women should adhere to this policy. There was a general consensus that the advice on alcohol consumption during pregnancy should be better thought out. Women are less accepting of the medical profession as they do not see medical guidance as the be all and end all or ultimate importance. The health education efforts were linked with a lack of trust as there is no perceived benefit to them. However Paige recognises that not enough is currently known about the risks and claimed that the advice airs on the precautionary side. Paige also highlights an awareness of the cultural difference between Scotland and America in its stance towards alcohol consumption during pregnancy and the way in which pregnancy guidance is accepted by women. In America, women can be prosecuted for child harm when drinking or taking drugs during pregnancy (Campbell and Ettorre, 2011) (for a further discussion of the legal implications of drinking during pregnancy please see section 2.11.1) we could query if we actually want the health recommendations within the UK to go like this.

#### **4.4. THE IMPORTANCE OF LAY KNOWLEDGE - DON'T NEED THE ADVICE OF A PROFESSIONAL**

As previously argued in Chapter 2, more credence needs to be given to the importance of lay knowledge (Blaxter, 1997, Davidson et al., 2008, Watkins et al., 2002). Women draw upon knowledge from their own experiences, the experiences of others and lay concepts that circulate in their cultural context as well as from expert knowledge. By treating a pregnancy as purely scientific, there is a failure to understand lay concepts of risk. Risk is commonly used in both expert and lay discourses, but often with conflicting concepts as Handwerker (1994, p.669) argues patients understanding of risk often differs from that of medical professionals and depends on their values, education, class and other markers affecting their location in the social structure'.

We know lay knowledge is important in decision making around other areas of women's health. The work of Hillary Graham (1976) reveals the importance of lay knowledge in smoking practices. Other authors also recognise the role of lay knowledge in decision making around health (Henderson, 2010, Popay and Williams, 1996, Popay et al., 1998). Because of this confusion or an uncertainty over the guidelines, women reported making their own decisions around what level of alcohol consumption would be acceptable during pregnancy, formed through their own lay knowledge, principles and knowledge of potential risk. This thus reveals the importance of lay knowledge in making decisions about your health as discussed by Crawford (1980) in the work into 'healthism' and the medicalisation of everyday life. Lay knowledge and the importance of risk (Beck, 1992) also bore an influence in women's decision making processes. The differing advice that women received was most evident through the lay advice they received from family, friends and peers. Three quarters of all the women interviewed were seen to draw some common-sense reasoning from this in-group peer advice and also from their own experience from previous pregnancies. Their choices also displayed the women's resistance to these discourses of authority and power. Skyla demonstrates the discourse that women want to make the decision around alcohol consumption during pregnancy themselves, thus reflecting the increasing importance of personal experience in health beliefs (Popay et al., 2003).

At times you don't always need a professional to get advice about something, quite a lot of mums might have come across or know about and you can share experiences.

Skyla, 42, Inverness

Peer knowledge and experience were therefore important within the decision making process. Despite an attempt to get abstinence from alcohol during pregnancy as a cultural norm in Scotland (The Scottish Government, 2013), women still feel that they have their own choice in the health decisions that they make over their body. The language selection used by the women reaffirmed the view that they had the option to drink or to abstain and that their behaviours could be influenced by their personal preference. They had a "choice" or a "decision" to make and this infers that some women still feel like they are able to opt to consume alcohol or not when pregnant, and that this choice was highly individualised. Through this process of decision making a theme of resistance emerged in a selection of the interviews. By continuing to consume alcohol during pregnancy, even at a low level of consumption, these women were resisting the expected or 'normal' choices as purported within the media by BBC (2012), Bennett (2007), Foster (2007) and Hope (2007) that they would make in regards to abstaining from alcohol whilst pregnant or trying to conceive.

The women in the study not only reported receiving different advice from different health professionals on the issue of the consumption of alcohol during pregnancy, but also that the evidence online, in the press or from pregnancy books was also contradictory. However, it is notable that some references used on the subject may have been published before the guidelines for alcohol changed. Women reported also receiving inconsistent messages from the media and friends, there was therefore an informal reliance on friends and family, and lay health beliefs (Popay, 1994, Popay et al., 2003, Popay and Williams, 1996, Blaxter, 1997) and it is evident that because of this, women are confused by what practice is safe from harm.

I remember having quite a big conversation with a friend at work of mine about this, and erm there's a lot of conflicting evidence coming about,

especially in the newspaper articles about how we have, err maybe one glass of wine, once a week and it does absolutely no harm

Paige, 28, Edinburgh

As Paige confirmed, these conflicting messages lead women to question the guidelines, and compare it to their own lay knowledge and that of their peers. Paige demonstrates how alcohol during pregnancy has become a popular topic which people talk about when women are pregnant. This in itself reveals how drinking during pregnancy has become a hot topic within the UK in recent times (Scotsman, 2006, 2007b, 2007a, 2008a, 2008c, BBC, 2012, Bennett, 2007, Foster, 2007, Hope, 2007, Johnson, 2007, Martin, 2007, Moran, 2007, Parry, 2007, Rose, 2007). Jennifer highlights these inconsistent messages, and the conflicting evidence, revealing that friends and family often encouraged her to drink whilst pregnant, yet concurs with the overall idea that drinking alcohol during pregnancy is not problematic.

I never felt like I couldn't say no, so that's what they were like and when her family arrived and her mum and that, they were like "you won't be drinking will you" and I was like "no, no, no", "but she can have one, she can have one" and her mum and her aunty were like "well she probably could have one but if she doesn't want to she doesn't have to, it's probably best that you don't have one". So she was saying like my friend was saying "oh just have one just have one", but then her family was saying "oh probably shouldn't even have one, you probably shouldn't"

Jennifer, 20, Edinburgh

Here Jennifer highlights the inconsistent messages which women receive from friends and family and highlights the importance of these lay discourses in her own decision making process around alcohol during pregnancy. It was apparent that the support that friends or family offered women in their choices around alcohol made a great impact upon their preferences and decisions around alcohol consumption during pregnancy. I would argue therefore that women seek to feel supported in their decision making process and aim to be as informed as possible before adapting health behaviours. It is therefore important that the impact lay knowledge has upon

women's choices around alcohol consumption during pregnancy and other health related behaviours is acknowledged. Notions such as "I drank when I had you, and you are fine" particularly resonated with the women and helped to justify their decision to consume alcohol. It therefore helped to legitimise their drinking by thinking about the general experience of women who have drunk alcohol to some degree and who have given birth to a healthy child.

Personal experience is important in decision making about health (Popay et al., 2003) and so is lay knowledge and the experience of others. There is trust based within real experience of family and peers, for example, other people who have drunk etc. and their baby was fine.

I did kind of think, oh well lots of people are pregnant and they don't think about it so and they don't know for weeks and they drink loads of alcohol, but that's true, it's still, it still would have been better if I hadn't got drunk. I, I didn't, it's not as if I sort of agonised over it for a lot of the pregnancy because I didn't really think that I had that much to drink, you know and erm, it was just it was just once so and also it was done and there wasn't really anything I could do about it, so I just had to forget about it

Rhea, 35, Edinburgh

As argued in Chapter 2 many women who do drink during pregnancy go on to have a healthy child. Linked to this is the notion that generations of women have drunk low levels of alcohol whilst pregnant in the past prior to this recommendation for abstinence. Across history, women even used to be advised to drink Guinness because of its high iron content. Yet Paige did discuss having seen the effects of alcohol in pregnancy having worked with women who used alcohol and drugs in their pregnancies. This was therefore key in her lay knowledge about the risks of consuming alcohol during pregnancy. As she described:

Before I had Declan that I had kind of seen the affects that alcohol in pregnancy can have.... Erm I think it's like one of those things though

whether people say well like “no one told me that”, and “I drank all this and I smoked all this and my baby was born fine”

Paige, 28, Edinburgh

When women feel that the advice and guidance that they are given about health choices during pregnancy is confusing and inconsistent and it is clear that they feel that they have to go on “instinct” and make their own choices, as Catriona described:

I do think that you need to go on instinct a bit about what seems right

Catriona, 29, Edinburgh

Catriona clearly felt that despite the recommendation for abstinence women still need to make up their own mind. This is also reflected within Zoe's comments:

I think you know people tend to just decide, they will make up their own mind. You know what's good for you what is good for the child, what you should not do and I think a glass of wine once in a while didn't affect anything, I mean look at her. I think I think she's very healthy, very happy

Zoe, 42, Edinburgh

Women are overloaded with different and contradictory health messages and advice (Lowe and Lee, 2010, Geddes, 2012, Mosley, 2013). Women receive messages regarding what food should be avoided, recommendations to breastfeed, ideal weight, smoking and now also receive conflicting messages around the level of alcohol that they should consume. By adding this message about alcohol on top of the other messages that women are receiving it is clear that women are feeling overwhelmed with the all changes that they should make. Some women in the study saw this as “extreme”, that it “goes too far”. Women hint at how they are not “superhuman” and do not feel that they can do everything that they should “perfectly”. Women aspire to be ‘good’ mothers but feel that the boundaries that they are set are being constantly changed. Are we therefore expecting too much out of women during pregnancy to expect them to adhere to a message they feel has no grounding when there are a lot of other changes they need to make. Wendy

recognises that expectations of women are now high, that there is so much you have to do in a certain way:

There are so many things in motherhood where you can feel guilty if you let yourself

Wendy, 33, Edinburgh

Consequently there are lots of things to feel guilty about if you don't do them correctly, as revealed within the 'good' mother ideology (Boyd, 1999, Kirkman, 2008, Lawler, 2000, Lupton, 2000, Lupton and Fenwick, 2001, Lupton and Schmied, 2002, May, 2008, Miller, 2005, Oakley, 1979, Phoenix et al., 1991, Radcliffe, 2011a, Reid et al., 2008). Refraining from alcohol has become another thing added to the long list of behaviours and expectations made of 'good' mothers. Women identified that it was important that they made their own choice. The importance of going on instinct was true for Elise who demonstrated a high level of self surveillance, over her alcohol consumption.

I hadn't drunk for about a week then and I didn't drink at all throughout the pregnancy, and the reason that I didn't was because my belief was that it was okay to have the odd glass of wine, and I think that's what the advice used to be and I'm not sure what it is now

Elsie, 42, Edinburgh

Elsie had a very strong sense of her limits and own boundaries when drinking alcohol. The use of phrases such as "I couldn't" reinforced her self-imposed limits around alcohol consumption, as she contently tried to avoid the risk of uncontrolled drinking especially in pregnancy. This significant concern over her drinking was founded because of her father's poor relationship with alcohol and the idea that drinking patterns could be inherited (Holloway et al., 2008). This revealed strong attitudes towards intergenerational relationships with alcohol. She described drinking in itself as a risk to her, and consequently drinking during pregnancy would constitute a threat both to the child and herself. She exclaimed that she didn't trust herself so abstained, revealing an individualised rational choice that was not affected by the medical recommendations. She indicated that for other women, who did not have issues around alcohol consumption, she saw no problem in the consumption of

a small amount of alcohol but her alcohol dependency makes this hard. Her choice was therefore framed around risks to her as an individual.

#### **4.4.1. Encouragement by family/peers to consume alcohol during pregnancy**

The importance of intergenerational transmission of norms became apparent in women's choices around alcohol consumption during pregnancy, and I have already argued practices are influenced by lay knowledge. The work of Beck (2002) into the individualisation of society reveals how science has failed, so inevitably people are returning to what they know, their own lay knowledge and that it matters what happened to their mother or father. This is evident from the literature around breastfeeding as the role of intergenerational health behaviours can influence breastfeeding (Grassley and Eschiti, 2008). Health care beliefs/practices are therefore transmitted intergenerationally; this is noted in the work of Blaxter (1981) into the health of children and Graham (1987), in hardship and health and women's lives for example, smoking (Graham, 1976, 1984, 1994).

The surveillance of women, especially around alcohol consumption during pregnancy by family and friends, was evident. At times women were actively encouraged to drink alcohol by their peer group and family. Women are therefore receiving mixed messages from different groups. Whilst reporting feeling scrutinised for drinking in some locations and by some people, women also reported receiving encouragement by family and friends to drink, as Jennifer explained:

Everybody says "oh it's okay, you can have one"... They were all like, "oh you can have one, you are allowed one, you know if you're not going to drink for the rest of the week, you're allowed say three glasses of wine" [later] Friends, they encouraged you to have a glass of wine they said it's okay you can have one

Jennifer, 20, Edinburgh

Women showed an awareness that their alcohol consumption was observed; nevertheless in some cases friends clearly encouraged women whilst pregnant to consume some wine (for more details on the surveillance of pregnant women please see Chapter 5). We can draw associations between these recommendations women received and the cultural context of alcohol in Scotland. It also needs to be



remembered that previous recommendations made to women that it was okay to consume alcohol at a low level may have been other women's experiences or the experiences of these women in prior pregnancies. It was evident that for nearly all of the women that the advice offered to them through friends and family emerged to be a large influence in their reasoning for consuming alcohol during pregnancy. As Catriona explained:

I think I may have had like one glass of wine which was, actually that was connected with my mother in law saying that she thought it was fine to drink during pregnancy

Catriona, 29, Edinburgh

When examining the reasons behind women's alcohol consumption during pregnancy it was evident that of women who drank, they did so because they perceived it to be their choice; however this was influenced by the sources of advice they received. Lay knowledge was therefore highly important in influencing women's decision making. A few women spoke about being actively encouraged to "join in" and have a drink or a family member had advocated it, as Olivia made clear:

Yeah I think I was about five months pregnant or something. And some older people were saying "oh just have a drink" like aunties and uncles or stuff and I was like no I'm fine and they were like "oh you have to have a drink" and "so well I'll have half a glass for goodness sake"

Olivia, 32, Edinburgh

Some women, however, found this lay advice to be given to them in quite a pressurising manner, which indicated the way in which some family or friends had clear expectations that women should drink during pregnancy, ensuring that they are therefore taking part in a social event or occasion. They therefore actively encouraged women to drink during pregnancy and thus formed a pressure for the women to consume alcohol during pregnancy; however some women paid no attention to this advice and avoided drinking.

Some of the other girls that I went to college with were like “oh just have one, have one for Annabelle, celebrate her birthday”... and I just, I didn’t sort of feel pressured, I thought to myself this is a situation where I potentially could be pressured into it

Jennifer, 20, Edinburgh

This notion resonates with the way in which the use of alcohol is embedded within our culture, that people put pressure on pregnant women to consume some level of alcohol. Alcohol is therefore a social product (For a further discussion of the social nature of alcohol see Section 4.4.2).

#### **4.4.2. Critique of how the idea of something for you versus for your child**

The ideas highlight the complexity behind women’s alcohol consumption during pregnancy. Women are clearly critical of the clinical messages and a ‘one size fits all’ approach. The way in which women are presented with the recommendations also reveals that health professionals even find it hard to apply indiscriminately these messages in their communication with women.

Ruddick (2007a, ; 2007b) has spoken about the emergence of a foetal/maternal conflict between mother and child. The choice of both Skyla and Paige and other women in this study highlighted an important choice in behaviour between doing something for yourself versus the impact it has upon the health and wellbeing of your child (for a further discussion of this foetal/maternal conflict see Chapter 2). As Bell et al. (2011) argue the new public health has shaped an increasing concern over individual responsibility and self control. In this particular study the women did not desire to be portrayed as uncaring women for consuming alcohol during pregnancy, constructing themselves as being responsible and ‘good’ mothers. This was evident in their constructions of lay discourses around consuming alcohol during pregnancy. As Catriona emphasised, a pro-active choice to avoid it had to be made:

I don’t think I drunk at all I remember, I think making an effort not to drink when I was pregnant

Catriona, 29, Edinburgh

It is important to consider how this develops the idea of the maternal-foetal relationship (Oaks, 2001, Casper, 1994) with a dichotomy between things for you versus things for your child (Lupton, 1999b). This is influenced by the ‘good’ mother ideology (Knaak, 2010, Lister, 1994, Letherby, 1999, Miller, 2005, Rich, 1997, Rothman, 1993, Shelton and Johnson, 2006). The lexical choice by Leah demonstrate the importance of lay health perceptions, as she demonstrated her certainty that she would not harm her unborn child, she using phrases such as: “I was sure” “I knew”, “it wouldn’t” to demonstrates her own very individualised notions of risk/choice. Her own lay knowledge and understanding meant that she is clearly very certain that a very low level of alcohol consumption is not a risk to the health of her child. By reiterating this and explaining:

I know it wasn’t going to have any particular damage to my children

Leah, 39, Inverness

Leah actually demonstrates awareness that the consumption of alcohol during pregnancy is potentially associated with negative harm and this is infused through the use of the word “damage”. The use of the word particular is interesting here, there’s a slight hint that it may be risky, but is very unlikely to cause harm. Although there is a risk that consuming alcohol during pregnancy could be detrimental and damaging to the health of the child, she others herself to this notion, and explains that her own alcohol consumption, because it was restricted and a low level of consumption, was not harmful. This is indicative of how some women do not believe that drinking alcohol at late stages is risky / unproblematic. For her it was a one off, Leah was keen to put pressure on this as an occasional behaviour that caused no risk as she does not want to risk being labelled a ‘bad’ mother. She wants it to be okay to receive some pleasure out of something which she thought was of no risk. Discourses around alcohol highlighted women’s restraint over their alcohol consumption, and the ways in which they carefully limited their consumption. Subtle phrases women used such as “kept it to”, touch upon this and demonstrate how a controlled form of drinking was maintained, therefore adhering to the behaviour of a responsible, ‘good’ mother.

You have to be much more responsible now that there's a little one as well

Neala, 30, Edinburgh

Neala also asserted that she “definitely said no”, emphasising both the definitely, and no. I would argue that she is trying to prevent herself from being judged as a ‘bad’ mother for drinking during pregnancy. These findings correlate with those of Rolfe et al. (2009) who argued that women employ a discourse of self control to resist stigmatising subject positions, protecting their moral status and presenting themselves as ‘good’ women. Adhering to gendered ways of drinking therefore acts to preserve femininity and to allow presentation in a good light, ‘protecting their own moral identities through positioning themselves as womanly and respectable’ (Rolfe et al., 2009, p.331). Women presented themselves as ‘good’ mothers by highlighting responsibility and restraint and that as women they were careful during their pregnancies and vigilant in their health behaviour. As Leah purported:

I was being cautious in my pregnancy in terms of no alcohol consumption, and healthy food and everything like that

Leah, 39, Inverness

The choice of behaviour for yourself versus the health of your child was also evident for Mya. She reveals how even her alcohol consumption after pregnancy was directly linked around her notions of being a ‘good’ mother and putting the health of her child before her own. She revealed this made her a mother who was quite paranoid around alcohol:

Drinking, I never touched a drop at all when I was pregnant...I mean after he was born I don't think I touched a drop of alcohol until he was about four months, because, I was so paranoid that if I had a drink then the fumes off my breath would (laughs) would affect him so I was a completely paranoid mother

Mya, 21, Edinburgh

The foetal maternal discourse was also true for other health behaviours. It became evident that women had to negotiate their behaviours around the notions of ‘good’

mothering, even if these ideas were influenced by their lay knowledge. Olivia recalled that she quit smoking after she had found out that she was pregnant, however she reveals that if it wasn't for the fact she was pregnant she probably would not have quit.

But I think I stopped smoking about a week after I found out, every time that I had a cigarette I felt horrendously guilty and actually when I stopped it didn't bother me. I don't think I would have stopped if I hadn't been pregnant, but when it was for someone else

Olivia, 32, Edinburgh

Women therefore pulled on the notions of responsibility that they now had as mothers. Choices around health behaviours were no longer made entirely for themselves but also had to include a consideration of the effects that they may have on their unborn child.

#### **4.4.3. The difference between how women approach other health messages in comparison to messages around alcohol during pregnancy**

An interesting finding in regards to messages upon alcohol consumption during pregnancy is how women's attitudes towards these messages differ in comparison to other health messages, for example, those regarding weight, exercise and supplements that should be taken, or foods that should be avoided during pregnancy. Tina highlighted the other changes that need to be considered when you become pregnant or are trying for a baby and how women consciously make these choices to ensure they are seen as responsible:

I was erm, very conscious about what I put inside my body...and tried to reduce my caffeine intake and eat healthier and have multivitamins or all that kinds of thing, I didn't completely cut alcohol out, but I did reduce what I was drinking

Tina, 32, Edinburgh

The women in this study appeared not to question some other health guidance for pregnancy such as banned foods or the recommendation to take folic acid, like they did around the recommendation for abstinence from alcohol during pregnancy. This

was evident through the account of Yvette, who highlighted that she took folic acid for five years, and “then started to really cut down, really think about how much I was drinking as well”. It can be inferred from this that other messages are not queried by women in the same way the recommendation for abstinence from alcohol during pregnancy was. Alcohol was not discussed in the same manner as other health requirements that were made of women, for example food groupings women were told to avoid such as unpasteurised cheese and pate etc. These food items were considered to be “banned”, and in general all women spoke about avoiding these completely. Yet for some women their discussions around alcohol indicated that it is not categorised in the same manner. Wendy’s description reveals how there is a difference between things that women perceive to be prohibited versus things they should avoid;

Then I started taking folic acid and after that it took about four months, erm and I didn’t eat any of the things that are banned, like brie and pate.

Wendy, 33, Edinburgh

The use of the word “banned” here invokes a strict idea; however it could be argued that the evidence-base behind this is stronger, and has also been around longer, there is inevitably a time lag between a recommendation and a behavioural change. Yet, how women interpret different guidelines is important in determining the recommendations that are given to them. Alcohol was not described as something that is “banned” during pregnancy, despite the new recommendation to abstain from it. It was therefore evident that some women felt that they had a choice to make with regards to choosing to consume alcohol during pregnancy or not. This choice was contrasted against other food sources or activities which were forbidden and things that you must take such as folic acid. Rhea mentioned, following the advice around food:

I took erm, I'm trying to think if I took the pregnancy advice about food and foods to avoid, erm I pretty much did, yeah erm I think you're supposed to avoid

Rhea, 35, Edinburgh

The way in which women negate these different guidelines and see things as choice versus more compulsory changes, is significant for the ways in which future guidelines are set. This difference could be potentially because of differences between needs and pleasures and also the medical evidence behind the messages. Guidelines that have not changed for many years are more likely to be followed compared to advice upon things such as alcohol which are changing and are also different between different countries. A dissonance emerges between the guidance that is given to women, versus the rules that women must follow to achieve the best possible health for their unborn child.

There's obviously the things that you're not supposed to eat when you're pregnant, which I had to cut out a lot of stuff that I like, cheeses and pate and err things like that

Neala, 30, Edinburgh

Women can therefore actively see the benefits of taking supplements such as folic acid because they are undoubtedly aware of the medical facts behind the negative consequences of not doing these things. In comparison they contest and do not seem to believe the evidence behind the guidelines for alcohol. I would argue that this is because of the confusion around these messages and a longstanding theme that women do not see the message for abstinence as directed at them. Instead they see it as power over their bodies by an unknown authority. They simply do not trust some messages in comparison to others. We need to consider the impact of the government setting guidelines that are not backed up by robust scientific evidence and the consequence that doing this may lead to a lack of trust, as is reflected in some women's interpretations and reflections upon the guidelines. Is it a case that women want alcohol and can do without other things or is it because the recommendations surrounding food have been in place for longer and that there is a lag in the uptake for abstinence? Alcohol was not seen as a 'banned' substance, in the same respect that other food items are. Is this because of the different notions of risk that are in place, or is it a case that women resent giving up alcohol because of the pleasure it brings? Women see the contradictory advice and are therefore sceptical of the advice they receive.

The only other health recommendation, except from alcohol that was slightly contested by some women, was the ‘breast is best’ campaign. This was in general by women who had struggled with breastfeeding and had negative experiences with members of the medical profession putting undue pressure on them to breastfeed due to its health benefits for the child. Yvette actively questioned the messages that pregnant women receive, querying the way in which policies are handed out *en mass* to women, with no consideration for women as individuals. Her narrative revealed the idea that women did reject and question the recommendation for abstinence from alcohol during pregnancy as a ‘one size fits all’ policy in isolation. Other health related recommendations were also questioned and scrutinised as Yvette highlights how strong messages around breastfeeding aimed at women, sometimes rebound and actually lead women to resist the messages that they are carrying:

So I think the breastfeeding propaganda actually backfired in my case  
and I know quite a few of the other mums I’ve spoken to feel similar

Yvette, 35-44, Edinburgh

Messages were therefore seen as misinformation and as very strong messages that lacked an awareness of women as individuals. The way in which women viewed the recommendations as ‘authoritarian’ had strong resonance with links to debates in public domain around breastfeeding. Women are aware that there is some level of debate within the public domain over which health behaviours women should follow. Yet Catriona feels that there is no longer a debate about breastfeeding, and instead feels that women are forced into breastfeeding. Feeling that this advice is “authoritarian”, she consequently finds it “hard to dissect”:

It’s pretty much stated in the public kind of domain that you should breast-feed, erm, but the reality of it is that most people don’t actually do that or they don’t do it for very long. I suppose in some ways that is out of sync with what people actually do erm, but, erm, maybe it has to be like that because maybe otherwise people wouldn’t even bother if there wasn’t sort of an authoritarian take on it...erm so I don’t think there’s a debate.

Catriona, 29, Edinburgh



Catriona resists the advice and questions its merit against other behaviours or substances which could prove harmful to the unborn child, seeing these authoritarian health messages as taking choice away from women. In relation to the consumption of alcohol whilst breastfeeding some women reported receiving a lack of information on what level of alcohol consumption is safe during breastfeeding, and in turn found this confusing:

What's confusing about the messages that women get, or certainly what I got, I got no advice about alcohol and breastfeeding erm because I think there is a big emphasis on not drinking while you're pregnant, and then it, it's as important if not more important to not drink, or to drink very small amounts when your breastfeeding and I didn't erm, I didn't really, erm I didn't kind of get any advice about that really,

Rhea, 35, Edinburgh

Rhea was not the only women to mention feeling confused about alcohol consumption during breastfeeding. Catriona also stated feeling confused by this:

Erm, and in fact I found that all thought that period and in fact still through breastfeeding that the advice is so confused about what your meant to do

Catriona, 29, Edinburgh

Neala however reported being aware that you're not supposed to drink during breastfeeding, but this was seen as something that was recommended and not an absolute that must be strictly followed:

Going back to the drinking thing I know if your breastfeeding you're not really supposed to drink, they don't recommend it, erm but again I'm not really drinking...but I know you're not really supposed to drink if your breastfeeding

Neala, 30, Edinburgh

#### 4.5. CONCLUSION

The importance of lay knowledge surrounding women's choices on alcohol during pregnancy was evident as several interviewees questioned the recommendation by challenging the effect that alcohol had upon the health of the unborn child. It was evident that women received inconsistent advice during pregnancy, both from medical professionals, peers, family and the media. It is also clear that not all professionals are 'singing the same tune' and that it is equally important how messages are given to women.

The previous recommendation given to women was that it was reasonable to drink a small amount of alcohol when pregnant; women inferred that as there was no concrete evidence to show otherwise, following this would still be reasonable. Women therefore are aware that there are risks of drinking a large amount of alcohol but question the risks posed by lower consumption. Across their narratives women called the recommendation for abstinence being pursued by health authorities into question, and even called the authority who gives out these messages into question.

Frequently participants had recalled being advised that drinking before they knew they were pregnant was unlikely to have caused any harm to their child. This also led the participants to be suspicious of the idea for absolutes as it is contradictory to the message for abstinence. Again this impacted the importance women gave to their own lay knowledge and that of their peers as they spent time researching the effects of alcohol during pregnancy for themselves. The mothers in this study showed a keen desire to form their own opinions, and not just willingly accept health guidance and recommendations without understanding the reasons behind it and the health benefits or gains that they will receive from it. This reveals that women do not want to be coerced into particular health behaviours which may or may not make a difference to the health of their unborn child. They do not resist this advice in order to put the health of their unborn child at risk; instead they do so to take control over their own choices and their bodies and seek to do 'what feels right' for them. The implications that this has for the way in which recommendations should be made to pregnant women is important. An examination of health promotion (Tannahill, 1985) found that knowledge did not necessarily influence behaviour; however women were aware of the risks of heavy drinking, and therefore did not drink heavily during their

pregnancies. They were aware that there is confusion surrounding what harm can be caused by low levels of drinking during pregnancy and the inconsistent messages they received led them to be less trusting of the message to abstain.

Finally, othering appeared to be an influential theme emerging from this research, especially when there is no conclusive link between drinking small quantities of alcohol and harm. The women simply did not feel the messages were aimed at them directly and this was influenced by the policy being broad and 'one size fits all'. The difference the recommendations for alcohol are followed in comparison to the way other recommendations are followed, for example dietary recommendations, reveal how women's attitudes differ to the messages around alcohol in comparison to other health messages they are receiving.

## **Chapter 5. The Surveillance of Women and the Discourse That You Should Abstain During Pregnancy**

### **5.1. INTRODUCTION**

The central concern of this research is to examine women's attitudes towards the consumption of alcohol during pregnancy. The study revealed that the majority of women who participated were aware of the change in guidance from the Department of Health in the UK on women's alcohol consumption during pregnancy that came into force in 2007 (Bennett, 2007, The Department of Health, 2007). This alteration in advice from one that sanctioned a small amount of alcohol as acceptable to one of complete abstinence was noted by some women; however these guidelines were not followed by every woman who participated in this study. Some women reported abstaining from alcohol completely during pregnancy; conversely some women also reported consuming alcohol at different stages during pregnancy. It is important that the reasoning behind their health behaviours is examined, so we can understand why women chose to continue to consume alcohol during pregnancy.

### **5.2. THE IMPORTANCE OF STATE REGULATION AND CONFORMANCE IN THE SURVEILLANCE OF PREGNANT WOMEN AND THEIR ALCOHOL CONSUMPTION**

The work of Foucault (1976) argues that surveillance becomes part of a function of what people do when they are being watched. This idea of ever present surveillance is that it becomes a state of mind, that people behave or conform to certain expectations of them, even when they are not being watched. In 'Birth of the Clinic' Foucault (1976) argues that power and knowledge are inextricably linked, and reveals how medical discourses are guidelines as to how patients should understand and regulate their bodies. Power is diffused through society and exists within the relationship between people as some people are thought to be authorised to discipline others. Powerful groups can therefore use their knowledge to subjugate those with less power by positioning them as 'other' or 'bad' mothers. The most effective and pervasive form of power occurs when people have learnt to exercise a self-discipline over their behaviour. By virtue of their socialisation, individuals will therefore believe it is appropriate to act in certain ways. However there is the capacity to resist

(as discussed in Chapter 2) and this resistance is also a form of power. Pregnancy advice has now come to be seen as pregnancy policing which Oaks (2001) argues is an example of what Foucault (1979) defines as ‘disciplinary technology’. This works to establish ‘norms against which individuals and their behaviours and bodies are judged and against which they police themselves’ (Sawicki, 1991, p.68).

Some women did conform to this; those who reported that they abstained. If the message had entered people’s consciousness we would argue that they would follow the recommendation to abstain and would behave whether they were in public or not. The fact that some women didn’t abstain reveals that for these women this is not something that has fully entered their consciousness. However because messages are inconsistent and delivered in an unclear way, the lay beliefs challenge the messages to abstain. This reliance on lay knowledge (as evidenced in Chapter 4) gives further evidence that women during pregnancy are not embodying the message to abstain. In the Foucauldian state, the message to abstain from alcohol during pregnancy would be internalised. Behaviour is viewed as deviant when it breaks the norm or rules or expectations that society have. It is therefore a feature of social situations that influences others to regard the person as deviant. There is a negative social reaction towards deviance and this is described as stigma within the work of Goffman (1963), stigma is therefore a consequence of being defined as different and as a target for discrimination. The discussion of moral panics by Cohen (2002) also alerts us to the way in which deviance is viewed within societies, and it is evident that this has implications for the moral panic surrounding women’s alcohol consumption during pregnancy as argued by Francis (2012). Drinking alcohol however does not necessarily mean that disciplinary technologies are not in place. Women also became part of surveillance as they othered themselves to the recommendation, drawing upon class based discourses of the ‘good’ mother (see chapter 8 for a further discussion of class).

Women reported undergoing other external forms of regulation, for example where women might get “funny” looks. Women within this study recalled feeling like they underwent surveillance because of their alcohol consumption, with some participants recalling conversations where other people had advised them that they shouldn’t drink when pregnant.

I remember actually having a conversation with my sister's boyfriend, but also a man erm, he's an American guy, quite intense, and he was saying that he didn't think women should drink at all during pregnancy and if there was anything wrong with the baby how could they possibly live with themselves and know that it was that, which I thought was a bit full on erm and it kind of offended me a little bit, strong moral ideas

Paige, 28, Edinburgh

This extract highlights the cultural differences, between America and Scotland. It also again reiterates the importance of gender as a man feels qualified to deliver this strong message to a woman. This reveals the masculine dominance over women as discussed (Phoenix et al., 1991, Mitchell and Oakley, 1979, Oakley, 1993, Schofield et al., 2000). Paige clearly felt that it was of note that this message was coming from a man, thus, highlighting the gendered forms of power that exist over women's bodies during pregnancy. Has the promotion of abstinence therefore encouraged more people to watch or survey women and their drinking? The theme of power as developed by Foucault (1979) is evident here, and the hegemonic power relations that exist are evident as women are receiving strong messages around the consumption of alcohol during pregnancy from men. The male is therefore the professional or 'expert' who women should be submissive to (Rothman, 2000, Oakley, 1979, 1993). Paige recollected that this man had very strong moral feelings around the consumption of alcohol which led her to feel quite offended by this hegemonic display of power over women's bodies. This acceptability that women shouldn't drink was mirrored in some other settings and most clearly again by Paige as she recollected purchasing alcohol for friends on a night out whilst pregnant:

When I went to a pub and I wasn't drinking anything myself but I was just going to bar, to collect drinks for people. I had just ordered a round and I had quite a kind of pregnant belly and I felt really that quite a lot of people were looking at me in quite a discouraging way, erm because I was getting the drinks

Paige, 28, Edinburgh

Paige demonstrates here that she felt her body was being surveyed by other people in the pub because she was purchasing alcohol whilst pregnant. Even though she was not drinking it herself, it is clear she found the process a little distressing and she was clearly under the public gaze (Lupton, 1997b, Armstrong, 1997, Davies and Allen, 2007, Turner, 1987, 1992). This serves to indicate further that there is an existing discourse that women should abstain from alcohol during pregnancy and that if women continue to do so they will be stigmatised for their drinking (Davies and Allen, 2007, Lupton, 1999b). This discourse possibly indicates a shifting perception, that it has become more normal for women to choose to abstain from alcohol during pregnancy or that expectations are now clearly that women should abstain from alcohol altogether. This is probably influenced by the change in guidelines and the increased attention that this matter is given by the media. Women are therefore inspected and have their behaviour judged to see if they align with this ideal of the 'good' mother who no longer consumes alcohol during pregnancy. Women are encouraged to ensure that they put the health of their unborn child first, over any expression of pleasure. Both examples given by Paige highlight the public expectations that were made of her as a pregnant woman and were not medical. These two sets of contrasting discourses highlight the very powerful messages women encounter. Despite this, some women reported encouragement to consume alcohol especially by family and close friends, and in some cases women were advised that low alcohol consumption is acceptable by health professionals. Contrastingly women also face judgement by some health professionals and by the general public if they chose to consume alcohol during pregnancy. Paige indicates that this alignment of attitudes towards the recommendation for abstinence has followed on from the change in the perceptions around smoking:

I guess the attitude to smoking in pregnancy is quite erm a judgemental one and I think alcohol has probably gone that way as well

Paige, 28, Edinburgh

Paige argues that the attitude towards alcohol consumption in pregnancy is becoming more judgemental and stigmatising, like the attitude towards smoking in pregnancy. The evidence detailing the risks that smoking poses to the unborn child is more definite (Oaks, 2001, Andersen et al., 2012, Fingerhut et al., 1990, Giglia et al.,

2007, Graham, 1976, Lawrence and Haslam, 2007, Lemola and Grob, 2007, Plant et al., 2002, Shoff and Yang, 2013, Waterson and Murray-Lyon, 1989) than the uncertainty which still exists around harm and moderate/low levels of alcohol consumption during pregnancy (Kelly et al., 2009, ; 2010, Knupfer, 1991, Plant, 1984, Stockwell and Room, 2012). If this becomes more of a stigmatised issue are we likely to push women to drink in private or in a home setting to prevent this stigma? It was clear that even some partners acknowledged that women should abstain from alcohol or lower their alcohol consumption when pregnant:

About the third thing that Aaron said after I told him that I was pregnant was that “it was a bit of a shame that you got so pissed on Saturday”

Rhea, 35, Edinburgh

These highlight the attention that women receive if they consume alcohol during pregnancy. Rhea’s partner emphasized that she shouldn’t really have drunk before she knew she was pregnant. Zoe reflects the lay health belief that you should cut down on alcohol consumption during pregnancy but she went on to say that she had drunk alcohol during pregnancy.

I got pregnant I just cut down or stopped the alcohol erm, I I would say that I think once in a while there was the occasional one or two wines and that yeah erm.... I think a glass of wine once in a while didn’t affect anything

Zoe, 42, Edinburgh

Zoe argued that it was okay if you didn’t completely abstain from pregnancy, yet she was clear to be seen as someone who was responsible in her health choices and implied that she believed there was no harm connected to occasional drinking.

### **5.3. THE IMPORTANCE OF PERFORMANCE IN THE USE OF PRIVATE AND PUBLIC DRINKING SPACES DURING PREGNANCY**

The work of Foucault (1979) draws on the use of the Panopticon (a model prison designed by Jeremy Bentham 1778) as a way of disciplining, which is used ‘to induce in the inmate a state of consciousness and permanent visibility that assures the automatic functioning of power’ (Foucault, 1979, p.201). Therefore surveillance



is permanent in its effect even if the action of it is no longer being used. This idea would therefore assume that women would not drink in public, if they had taken the surveillance of their drinking into their consciousness. The work of Goffman (1971) also highlights the idea that our roles are subject to change, and that our performance of a role as is akin to acting on a stage. The self is therefore seen as a social actor. Goffman (1971) defines these strategies of 'self presentation' that actors can devise to create particular impressions. In this sense the self is constantly moving and our roles are negotiated as we tailor our performances to the demand of the situation, between the 'frontstage' arena, where publicly visible characters are performed to the 'backstage' area where actors can keep their 'identity equipment' and can relax out of role. This alludes to a notion of an authentic self that is rarely allowed expression in the public realm. This theory is applicable to the way in which women in this study used different spaces in their negotiation of drinking during pregnancy. As they acted out different roles they don their 'frontstage' in public settings and the 'backstage' in private to prevent themselves being stigmatised for their consumption of alcohol during pregnancy.

#### ***Private drinking/drinking in the home – 'a behind closed doors sort of thing'***

In 2009, 54% of women reported that the place where they mostly drank was at home (NHS National Services Scotland, 2010). Holloway et al. (2009, p.823) argue that the debate on binge drinking within the UK has masked the problem of domestic consumption and 'left those drinking to harmful/hazardous levels in the home unwarrantedly insulated from concern'. The most popular drinking venue with both men and women is now their own home (Holloway et al., 2009, Valentine et al., 2008). Foster et al. (2010) argues that there has been an increased level of harmful drinking among women which is linked to greater home drinking. Traditional gender drinking norms saw public drinking spaces as male, the pub was a key site for the reproduction of hegemonic masculinity (Campbell, 2000a) and private spaces such as the home as the drinking landscape for women (Holloway et al., 2009). Holloway et al. (2009) also argue that the home remains a more popular drinking environment for women than for men, with drinking as a domestic experience taking place also in restaurants and the homes of friends and family. This has resulted in the taboo subject of women's drinking, remaining hidden within the privacy of the home (Plant, 1997, Rolfe et al., 2009).

The presence of women in public drinking environments not surprisingly differs with age, and we can understand that different stages in the life-course also bear importance on this, with mothers having less time to go out and consume alcohol in public areas, due to family constraints and notions of maternal responsibility. The reduction of alcohol at the life stage of motherhood is particularly common (Waterson, 2000b) and this is significant when we examine the localities of where women consume alcohol during pregnancy. The use of public and private drinking spaces by pregnant women needs to be examined. Foster et al. (2010) argue that previously there was an increase in women drinking in these settings because of the exclusion of women from other drinking environments, and this has in all probability had an impact on alcohol consumption during pregnancy. Women are probably more likely to drink in private environments if they feel that there is surveillance over their drinking during pregnancy and they can therefore escape the risk of being stigmatised. While some women within this study perceived drinking low levels of alcohol during pregnancy to be a socially acceptable behaviour, the use of drinking spaces during pregnancy was meticulously negotiated. Many women only chose to consume alcohol during pregnancy within private spaces, such as the home setting, whereby ensuring that they were 'safely' liberated from the public gaze of others who did not think it was acceptable to drink during pregnancy. As Paige claimed, there are places where you can do it:

So I think it is a kind of a behind closed doors sort of thing, so if you do drink in pregnancy then there are places where you do it where other people err won't see it, or at a wedding [later] When I was pregnant and I had some wine, I think the first time that I had wine was when I went down to stay with my parents, and I felt more comfortable there because it was in a meal setting, and I had about a glass and a half of wine

Paige, 28, Edinburgh

Paige perceives that her low level of consumption of wine is a pleasure, a luxurious commodity and is viewed as an accompaniment to food (for a further discussion of these themes see Chapter 7). Drinking wine within this context is seen as unproblematic; however in the above quote, Paige clearly demonstrates how she felt more comfortable drinking during pregnancy within a private home setting than in a

public location. By conducting this behaviour in a meal setting it appears more cultured and private, but because it was only in front of her family, Paige noticeably felt more secure. Drinking in private ensured that she was concealed from the gaze of others, thus highlighting her awareness that there are locations where it is acceptable to consume alcohol during pregnancy and places where you would abstain.

By stressing that drinking during pregnancy is a “behind closed doors” activity, Paige shows an awareness that drinking during pregnancy is a stigmatised activity and knowledge of the discourse that women should abstain from alcohol during pregnancy. Paige demonstrates an attentiveness that “other” people may make negative judgements of her because of this choice, and therefore she chooses to drink during pregnancy in a secretive manner where others don’t see it. She does not expand on who she defines as this “other”, but by conducting her drinking within a home setting she alleviates any anticipated judgement from others that she may be a ‘bad’ mother. The home remains a popular drinking environment for women during pregnancy, as it is a specific location where drinking during pregnancy is accepted and legitimised. Paige demonstrates that drinking during pregnancy is easier, when conducted within private settings. Florence highlights how it is acceptable to drink during special occasions; however it should be conducted in private or amongst close friends:

I had my thirtieth when I was pregnant as well, and we went away, like a few friends went away up to well an hour away to some lodges, erm which was arranged by my husband and my friends, and I had a glass of champagne that night

Florence, 31, Edinburgh

It is apparent therefore that women are likely to choose to consume alcohol during pregnancy when they are away from gaze of strangers. More women reported drinking within the home setting and this aligns with research by Foster et al. (2010) indicating that women are more likely to consume alcohol within the home setting. Skyla also reported drinking in a home setting during pregnancy, primarily to negate the gaze of others and prevent becoming stigmatised for this behaviour.

A little bit at Christmas, Christmas dinner and maybe just one glass with a Christmas meal, and maybe a little mulled wine at Christmas eve. Erm the second one (second child) didn't include Christmas so. I did have little bits now and then but it would be, I would say when we were having a meal with friends or on a more social occasion

Skyla, 42, Inverness

Consuming alcohol during pregnancy within the company of close friends indicates that women are more likely to consume alcohol around people whom they trust, as pleasure and sociability are themes which influenced women's alcohol consumption. Skyla reported drinking at social occasions during pregnancy, so she is able to take part in the celebration; this is subtly highlighted as she chose to drink with friends and at Christmas. She highlights an idea that during pregnancy you still have to ensure that you are limited in your alcohol consumption, as her consumption of alcohol consisted of "little bits", "now and then" (see above quote). This highlights the theme of responsibility. Being a responsible mother towards the unborn foetus means that you need to be responsible in your drinking choices.

### ***Public drinking***

Despite the risk of being stigmatised, over half of the women who reported consuming alcohol in this study reported continuing to consume alcohol during pregnancy in public settings. As the following quotes highlighted, many of the women in the study drank a low level of alcohol whilst out in public and generally this took place whilst having a meal with family or friends. Catriona provided an example of this:

I had a glass of wine we were at Pizza Express

Catriona, 29, Edinburgh

Although Paige (see preceding quotes) also commented on drinking during pregnancy being a "behind closed doors" behaviour she also reported consuming alcohol in public within a meal setting. Eilidh also reported drinking in public whilst having a meal:

Err when I was pregnant with Mina I think I was out for dinner one night and I think that I had a glass of red wine with my dinner but that's, that was it you know

Eilidh, 35, Inverness

This impact of place is important for our understanding of why women drink during pregnancy and has connotations with the way alcohol is in itself embedded within our society. It is culturally acceptable and often expected that if you go out for a meal for a special occasion, or to a wedding that there will be alcohol present and that you will partake in consuming alcohol, especially in a meal setting where alcohol is viewed as an accompaniment to food (see Chapter 7 for a further discussion of this theme). Although public, weddings are perceived to be an acceptable venue for consuming alcohol during pregnancy, these celebratory occasions do not seem to have the same weight attached to them as drinking in other public spheres such as the pub. There is therefore this interesting dualism of drinking in private versus drinking at a wedding.

Drinking during pregnancy for acts of celebration appears to be accepted and legitimised. The consumption of champagne at weddings was the most common location for drinking during pregnancy amongst the women within this study. Although a public site, the act of celebration at these occasions serves to legitimise it as an acceptable behaviour. There were some women in the study who recalled drinking at weddings as the only time when they consumed any alcohol during pregnancy. As Hermione commented:

When I was pregnant, the only alcohol I had, was maybe a glass of champagne at my wedding

Hermione, 37, Inverness

Olivia also mentioned drinking champagne during pregnancy at a wedding:

When I was pregnant, erm I never drank at all apart from I was at a wedding, I think maybe about five months, and had like, half a glass of

champagne, I didn't even have a drink at Christmas because I was worrying about it

Olivia, 32, Edinburgh

Consuming champagne or wine at weddings is identified as an occasion where women felt they were 'allowed' to drink during pregnancy. Despite this being a public setting, the presence of perhaps friends and family encouraged women to partake in the celebration of the day. Women were clearly more involved in the day by consuming alcohol at a wedding. It is interesting in the quote above where Olivia spoke of choosing to consume alcohol at a wedding; she still avoided it at Christmas, another celebratory event when several women in the study spoke about enjoying a drink. Olivia demonstrates here that she chose to avoid alcohol at Christmas because she was concerned about drinking during pregnancy; this is surprising given her choice to consume alcohol during the wedding. Perhaps here Olivia is trying to identify herself as a 'good' mother, the idea of which drinking during pregnancy and putting the health of your child at harm goes against. Here Olivia hints that although she consumed some champagne at a wedding she is a responsible mother, and did not drink all the time throughout her pregnancy.

By the process of power as defined by Foucault (1979) and the dimensions of surveillance, following the ideas of state regulation and conformance I would argue that if women had been fully conscious of the messages around abstinence from alcohol during pregnancy, it would be expected that by the process of self-discipline that they would abstain from alcohol. This ever present surveillance projects a state of mind that people would conform to the abstinence policy even if they were not being watched, for example in the private sphere. Because some women did abstain yet those who did not continued to drink at home highlights that the message for abstinence hasn't really entered the women's consciousness. If it had it would be expected that a woman would conform to it, whether in public or not. It is apparent though that some women were still aware of external sources of surveillance. These external forms of regulation monitored their consumption of alcohol during pregnancy, and women had to be careful of these to ensure that they did not become stigmatised for their health behaviours. This could be, in part because as discussed in Chapter 4, inconsistent messages are being given to women surrounding their

alcohol consumption during pregnancy. These messages are causing confusion, and it is apparent that lay beliefs are challenging these messages. This gives further evidence that women are not fully embodying the message to abstain.

#### **5.4. THE DISCOURSE THAT YOU SHOULD ABSTAIN FROM ALCOHOL DURING PREGNANCY AND ABSTINENCE AS A CULTURAL MARKER OF PREGNANCY**

The guideline adopted by the Department of Health (DoH) in the UK advises that women should avoid alcohol whilst pregnant or trying to conceive (The Department of Health, 2007). This parameter therefore covers two separate scales: women who are pregnant and women who are trying to conceive. This has led to the targeting of different audiences, women who are actively trying to conceive versus women who have unplanned pregnancies, highlighting what Griffiths et al. (2008) call the problematic dichotomy between ‘planned’ and ‘unplanned’ pregnancies. Subsequently all women of childbearing ages are targeted by the idea that women should abstain if they are trying to conceive, ensuring that we protect the foetus from harm at the risk of having an unplanned pregnancy, given that women’s alcohol consumption in general has increased in Scotland to a worrying level (NHS Health Scotland, 2009, A National Statistics Publication for Scotland, 2012, Catalyst Health Economics Consultants LTD, 2001, Scottish Executive, 2003, Information Services Division Edinburgh, 2010, The Scottish Government, 1997). Is this message for abstinence therefore another way of controlling women’s alcohol consumption patterns in general? This discourse that women should abstain from alcohol during pregnancy has evidently become acknowledged. Some women within this study revealed that people had automatically assumed that they would (or had) abstained from alcohol during pregnancy. Paige highlighted this feeling that there was an expectation that you should abstain:

I think it’s almost kind of expected now that if you’re pregnant then you don’t drink anything... But I think much more it used to be that people would assume that you are not going to drink anything during pregnancy, and a lot of people said to me oh it must be great to have a drink now that you’re not pregnant, erm kind of assume that that’s what you’ve done

Paige, 28, Edinburgh

Paige indicated from her experience that it did not just feel like people were advising her to abstain but abstaining from alcohol consumption during pregnancy had become an expectation that others had. The moral connotations of this are evident and clearly relate to the ways in which power and control are asserted over women's bodies as examined in the work of Foucault (2000). It could be inferred from this that the introduction of the promotion of abstinence for women whilst they are pregnant or trying to conceive is becoming part of the social expectations that society has on a pregnant women and an appropriate way to act during pregnancy. Abstinence from alcohol during pregnancy is therefore in some cases becoming a customary part of pregnancy and, reflecting attitudes similar to those found within America.

For example women who opted to consume alcohol during pregnancy went against the general 'rule' that women should abstain from alcohol as purported frequently by the media in the examples of Barnes (2012), BBC (2006), Bennett (2007), Child (2012), Mosley (2013) and Scotsman (2008a). The message for abstinence during pregnancy is therefore revealed in these different forms. As discussed in Chapter 2, the prevailing attitudes toward alcohol consumption were touched upon in a popular UK Television soap 'Coronation Street' and this therefore reflects prevailing cultural assumption about how pregnant women should behave.

From the narratives of the women in this study there was an awareness that abstaining from alcohol as a woman has therefore become synonymous with pregnancy. Waterson (2000b, p.5) argues that abstaining from alcohol has become 'a pregnancy ritual', so much so that not drinking is now seen as a predominant indication of pregnancy. Waterson (2000b, p.5) argues that this has now reached a 'taboo status', therefore sending a powerful message to women about the acceptability of consuming alcohol during pregnancy. Again Paige summarises this:

I did find a lot of people at the very beginning when I was trying to keep it quiet that I was pregnant, if I said that I didn't want a drink people would immediately assume that you are pregnant.... so I think there's a very strong link between not drinking and pregnancy [later] I think I went for a work's night out, and I wasn't drinking there but I think you could



get a free drink if you were bowling, and when I told one of my colleagues that I was pregnant she said oh I knew you were pregnant because of that night out

Paige, 28, Edinburgh

Strong assumptions therefore exist that if women do not drink alcohol then it means that they are likely to be pregnant. Paige also highlights the way in which women are observed. The work colleague guessed that she was pregnant because of this one night when she had abstained. Because not drinking was perceived to be a signal that women were pregnant, this was something that women had to negotiate at the early stages of their pregnancy where they had not yet informed everyone they were pregnant and were trying to keep the pregnancy secret. For women for whom alcohol formed part of their social life, this was therefore problematic, as they felt that being seen socialising and not drinking would “give the game away”:

I think with me it's probably a bad thing, but I think the same goes for a lot of my friends as well, for me it was very difficult to keep it a secret because people are used to seeing me I'll have a glass of wine on a night out, and erm the fact that I wasn't, it's okay you can get away with it the first couple of times saying that you're not well or your on antibiotics or whatever but people see a pattern and they just say “are you pregnant?”... And I really didn't want to tell anyone so that was really difficult because it was a wedding and normally everyone was having a drink... so it was actually a real relief when we could tell people because it ended up that after that wedding, I basically just didn't really go out I didn't attend any social events because I felt it was quite stressful trying to keep it a secret, partly because I really wanted to tell people, but just because I knew people would guess, and I didn't want to be asked

Florence, 31, Edinburgh

Florence highlights the way in which alcohol has been normalised for women in Britain. This resonates with the findings of Griffin et al. (2009) who argue that alcohol is normalised within the culture of the UK. Lupton (1999b, p.61) argues that ‘through normalisation, individuals may be compared to others, their attributes

assessed according to whether they fall within the norm or outside it'. There are very clear assumptions that not drinking equates to being pregnant. This indicates how alcohol has become so culturally sanctioned within the UK that not drinking is now considered to be unusual itself. Drinking alcohol is normalised in Scotland (Emslie et al., 2012). Indeed alcohol is rooted deeply in Scottish culture and industry. As a large part of the social life in Scotland, many seem to find it strange if someone abstains from alcohol. Elsie demonstrates this in her reaction to thinking her friend's boyfriend was unusual because he didn't drink:

In my past if somebody said "oh I've got a new boyfriend" for example and he doesn't drink and I would think god he sounds like a weirdo you know he must be really boring, and because alcohol is so erm part and parcel of our social life, and it's so socially acceptable, it's actually really difficult to not drink and still kind of be in be in our society, you know

Elsie, 42, Edinburgh

This was similar to the work of Emslie et al. (2012) in the research into men's and women's accounts of drinking in their mid-life, who found that drinkers were portrayed as fun and non-drinkers portrayed as boring. In work on the understanding of sensible drinking, Fry (2010) highlighted how the abstainer or infrequent drinker has a sense of not belonging as they were not part of the accepted cultural norm of intoxication. I would argue that women who are pregnant in some cases also felt that they no longer belonged to the culture of intoxication, as when pregnant it was assumed by some that they would abstain from alcohol during pregnancy.

Women therefore have to develop strategies/excuses or a cover story to explain to friends and others why they were not drinking. They are aware of the surveillance that exists over women's bodies and the discourse that they should abstain. This concept of surveillance works to enable or constrain activities of those monitored. Foucault (1979) argued that it operates in so many spheres of life it is now hard to ignore. Public perceptions and expectations that women should refrain from consuming alcohol during pregnancy are evident here, in the sense that women should be abstaining. This conveys a message that 'good' mothers are responsible and therefore should abstain from alcohol during pregnancy. Because of the

normalisation of alcohol, abstaining consequently becomes a tell-tale sign that they are pregnant.

The narratives revealed the subtle and not too subtle ways through which women were aware that they were being constantly monitored and surveyed represents the increased involvement of a frequently male medical profession over the functioning of women's bodies (Armstrong, 1997). For some women trying to keep their pregnancy a secret, for the first 10 or 12 weeks, resulted in stress and consequently their becoming isolated., they were aware of the medicalisation, the process by which medicine is a social institution, takes over a range of activities which were initially outside of its periphery (Popay and Williams, 1996, Mitchell, 1976). This was also influenced by the notion that women who drink during pregnancy are viewed to be deviant and needing to be controlled by society.

The surveillance of women and their alcohol consumption is evident. Not drinking for a woman becomes a cultural marker of pregnancy and thus generally means that people suspect her of being pregnant. This reveals that women are still being more scrutinised in their alcohol consumption than their male counterparts. Because of the normalisation of alcohol drinking is culturally sanctioned and not participating is viewed as strange, people consequently are increasingly aware if you are not drinking as it seems unusual. Recent work on trying to lower alcohol consumption within Scotland has focussed upon trying to make individuals more aware of drinking limits and guidelines and to have two days alcohol free each week (NHS Health Scotland, 2009). However in recent years there has been a cultural acceptance of drinking, especially for women as they are targeted specifically as alcohol consumers. We therefore need to consider the way we culturally view alcohol consumption, with excess being normal, and what the impact of this is on pregnancy. The moral judgements that are made of pregnant women are evident from the way in which some people guessed women were pregnant when they abstained from alcohol:

And some people can just tell that you're pregnant, even if you're not telling them, they can just tell. It's just funny, when you do tell them because they were just like "I knew, I just knew because blah blah blah"

or if you go out with them drinking you know, if you didn't have one drink you know that was funny as well.

Neala, 30, Edinburgh

The normalisation of alcohol consumption in Scotland has made hiding pregnancy for the first trimester more difficult, as women wish to keep their pregnancies private in this period due to the risk that is present for their foetus during this time period. This proved stressful for many women as they became aware that they were being watched. The narratives therefore gave an indication of the gaze that women underwent and the general suspicions that people had of them.

***Tactics women develop to hide that they are abstaining from alcohol***

Because of their awareness of the subtle surveillance over them and their health behaviours during pregnancy, many women reported developing tactics for not drinking so that people would not know that they were pregnant. This was often within the first 12 weeks of pregnancy, but longer for some of the older mothers in the study such as Elsie who was aware that because of her age she was at higher risk of complications. Florence reveals the different methods of distraction that she created to hide the fact that she was abstaining from alcohol.

I just said that I didn't feel great and wanted to save myself for the wedding, which is why I wasn't having a drink, erm and then the day of the wedding I decided the best tactic instead of saying to people you know that I'm not drinking or I didn't feel well or was on antibiotics was basically let people think I was, and not draw attention to it. So I just accepted a glass of champagne, so I basically walked around with it and then laid it down because the wedding was so busy there were about two hundred people there so I just laid it down and forgot about it

Florence, 31, Edinburgh

Florence reveals how it is easier to hide the fact that you are abstaining from alcohol at certain times, reporting that she found the night before a wedding difficult but then found it easier at the wedding when amongst a large amount of people. Women were therefore aware of surveillance, carried out over them, and the expectations that

are in place of how women should behave. Women therefore develop controls to resist being stigmatised for their behaviour or 'outed' as pregnant. As the following extracts from Wendy's narrative demonstrate:

There was red wine and white wine at the table and I was the only person at our table drinking white wine and the white wine bottle I had poured one glass and then I didn't have it I just put it over to Rory, so my mum was at that table and my sister in law and she doesn't drink she's Muslim, so they erm both noticed that the white wine bottle wasn't going down. So then they started watching me and realising I wasn't actually drinking, so we weren't being as discrete as we thought we were... I kept handing them to my husband cause we hadn't told anybody so I keep handing them to him and then he would have to drink them so that no one would notice that I wasn't drinking, but in fact everyone noticed and guessed [later] Those two were watching me closely so they realised that I wasn't drinking my champagne and so, no-one said anything but when I told them I was pregnant a few weeks later they had err suspicions

Wendy, 33, Edinburgh

These extracts represent the gaze that women feel and the tactics highlight the different reasons pregnant women may give for not drinking when they do not want people to know about their pregnancy. These experiences reveal women's behaviours are still closely regulated and the gender roles of women as child producers are still evident here as they risk that they might be discovered. Women therefore developed these avoidance strategies due to the ongoing perception that abstaining from alcohol means that you are pregnant.

***Reasons why some women in this study abstained from alcohol during pregnancy***

The perceived negative health implications of consuming alcohol or the change in guidance were not given as a reason why a few of the women in the study reported abstaining from alcohol completely during pregnancy. Some women reported having had previous negative experiences with alcohol and therefore generally abstained during pregnancy. Other mothers reported their being physically unable to drink because of morning sickness, or because they simply didn't fancy it. One woman in

the study spoke of avoiding alcohol in general because she had a low tolerance to it, finding that consuming alcohol in general gave her negative physical side effects.

Wine pretty much has a sort of an acidic effect on my stomach erm so anything that I drink, it burns my stomach quite badly, and I tend to avoid drinking altogether, so even before I ever considered getting pregnant I pretty much knocked it on the head with regards to any alcohol

Imogen, 32, Edinburgh

Although abstaining from alcohol during pregnancy because of her intolerance to alcohol, Imogen suggests that women in general do need to make a consideration of limiting their alcohol consumption when trying for a baby. Some women, such as Florence reported not desiring to drink during pregnancy; however she indicates that she would have had a drink if this wasn't the case:

I could have a drink, and I just didn't have it, I just wasn't interested

Florence, 31, Edinburgh

Florence recognised the pleasure that drinking alcohol brings, and the discourse that it is okay to drink during pregnancy. Indeed Florence did later in the interview report consuming alcohol during pregnancy. Rather than this dissonance being because of the issues around self-reporting of alcohol and the worry of being stigmatised for reporting alcohol consumption during pregnancy, this admission can be related to the telling and re-telling of stories and the way in which stories are never told the same way (Charmaz, 2002). A few women reported initially that they abstained but later in their narrative described instances where they had consumed alcohol during pregnancy. This is not surprising given the negative stereotypes that exist regarding alcohol and pregnancy. Women may have initially been afraid of being stigmatised for their alcohol consumption but this may also have occurred due to the general problems that exist in the self reporting of alcohol as described by Seppä (2006) (see Chapter 3 for a further discussion of these). All women, however reported 'cutting down' on alcohol, and were keen to stress that even if they did consume alcohol during pregnancy that it was a low level of consumption.

A proportion of women identified with being unable to consume alcohol during pregnancy because they found that they suddenly disliked the taste for alcohol or suffered severe morning sickness, which prevented them from being able to drink even if they wanted to. Morning sickness was a common reason that the women gave for not consuming alcohol whilst pregnant. It was a case that they couldn't drink alcohol for a period during pregnancy, even if they sought to. For some women this only lasted for the first and second trimester and meant that they were able to consume alcohol at later stages in their pregnancy, as these participants highlight:

I didn't really feel like drinking, I felt quite sick for weeks after that so I didn't drink at all until later on into the pregnancy...Once I stopped feeling sick after the first three or four months I did feel like having a glass of wine now and again so err I did

Rhea, 35, Edinburgh

Once morning sickness had passed, Rhea desired to consume alcohol so she did. Alcohol was not consumed at the start of the pregnancy because of the morning sickness being a physical reason and not through choice or an idea that she should abstain from alcohol. This was not an isolated case as other women also reported having bad morning sickness for first few months:

I had a bad case of morning sickness with my first pregnancy

Zoe, 42, Edinburgh

Morning sickness and the associated heightened sense of smell restricted women from consuming alcohol during pregnancy. Skyla reported that the taste and smell of alcohol made her feel sick, especially during early pregnancy. For the women who mentioned this, their reasoning for abstaining from alcohol during pregnancy was, therefore, not always because of an innate feeling that they should restrain but because they felt they were physically unable to drink. They therefore did not abstain because of a choice to abstain. The recommendation for abstinence was therefore not always stated as the main reasoning for abstaining, although this does not mean to say that this didn't have an influence.

## **5.5. THE IMPORTANCE OF TIMING AND THE NOTION OF RISK. THE DIFFERENCES BETWEEN THESE FOR PLANNED VERSUS UNPLANNED PREGNANCIES**

There is the idea that pregnancy as a whole is a natural period, however we can examine pregnancy as a series of events. The first stage is not knowing, then the stage of pregnant but not showing, so only the mother and father or close family know and finally there is the point where bodily changes reveal to the world that you are pregnant.

The difficulty in understanding FAS means that there is room for ambiguity and the conflicting nature of advice explains why there are inconsistent health messages (see Chapter 4). Some reports on the harms of alcohol during pregnancy suggest a dose response relationship (Streissguth et al., 1989, Patra et al., 2011), yet some research indicates that the duration of exposure and timing of alcohol consumption have important impacts for foetal health (Autti-Ramo, 2002). As discussed in Chapter 2 the relationship between the timing of exposure to alcohol consumption and foetal harm has been questioned. The amount of alcohol a woman drinks around the time of conception has also possible links to harm as Plant (2008) examines many women do not realise that they are pregnant for at least 2-3 weeks. Edwards and Werler (2006) have also argued that alcohol has the potential to impair a woman's recognition of pregnancy by disrupting her hormone cycles, thus potentially women may continue to consume alcohol unknowingly pregnant. What is defined as the time to recognise pregnancy may therefore be important given that research in the UK by Barrison and Wright (1984, p.168) highlights how 'pre-conceptual and early pregnancy drinking appears to be most damaging as many women are not diagnosed as pregnant until 8-12 weeks after conception' Drinking patterns prior to the conformation of pregnancy may therefore potentially impact upon foetal growth Waterson and Murray-Lyon (1989).

It has been argued that there is potentially more risk to the foetus by drinking at the start of the pregnancy than drinking at the end as this is when the foetus develops its facial features. Until it has grown a liver the foetus itself is unable to process any alcohol which may pass to it through the placenta. Yet in their studies into alcohol and pregnancy, Jesuratnam et al. (2011) found that a third of women thought consuming alcohol during pregnancy was safest during the first trimester. Barrison et



al. (1985) argue that despite reduction of alcohol consumption during pregnancy, heavy drinking before pregnancy may also potentially be detrimental to the health of the foetus. The time it takes to recognise pregnancy is therefore significant and is particularly influential given the change in recommendations for abstinence in 2007 by Scotland's chief medical officer (SMO) from alcohol during pregnancy and also whilst trying to conceive (The Scottish Government, 2008a). This is why the call for abstinence whilst trying to conceive has been put into place. Women are therefore being encouraged to lower their alcohol consumption whilst trying for a baby to ensure that they don't consume any alcohol and are, as a result, being encouraged to monitor their contraceptive protection to ensure they do not fall unknowingly pregnant. The unplanned pregnancy therefore risks foetal harm, meaning therefore that all women of childbearing age are the target for this recommendation. By asking women to abstain from alcohol before pregnancy, this then extends the medical gaze to all women of childbearing age.

Differences in the amount of alcohol consumed before the realisation of pregnancy were apparent between the women in the study who were actively trying to get pregnant versus women who had unplanned pregnancies. Women in general who were trying for a baby mentioned lowering their alcohol consumption whilst trying for a child or abstaining from alcohol completely during this time. On the other hand, many women within the study reported drinking or being drunk before they knew they were pregnant, which for many women resulted in feelings of regret, guilt, worry and anxiety about the effects that this may have on their child (for a further discussion of this see Chapter 6). For women who have unplanned pregnancies, their level of alcohol consumption may not be self-monitored or something they even considered altering, and their alcohol consumption is therefore unproblematic and not perceived in any way as risky behaviour. This pattern aligned with the findings of Kelly et al. (2008, p.4) who in their study of light drinking in pregnancy reported that women having planned their pregnancy were 'slightly less likely to be moderate (5.2%) or heavy/binge drinkers (1.8%) compared with mothers who had unplanned pregnancies (6.7% and 2.7% respectively)'. Skyla was an example of a mother within the study who had abstained whilst trying for a baby:

We had been trying so I hadn't been drinking for several months leading up to that until I knew whether I was pregnant or not

Skyla, 42, Inverness

*Negotiating when it is okay to drink during pregnancy*

There was a decline of alcohol intake during pregnancy amongst the women in this study with some women reporting completely abstaining from alcohol during their pregnancy, however among some of the women who consumed alcohol during pregnancy there was a trend for abstaining from alcohol specifically during the first trimester. This finding coincides with the opinion of Malet et al. (2006) who, in their study of alcohol consumption during pregnancy within France, found that the majority of women reduce their alcohol consumption during this time. Despite the risks to foetal health continuing to be greatly contested amongst health professionals and within the medical literature, in addition to the recommendation for abstinence from alcohol during pregnancy, NICE guidelines state that women should avoid consuming alcohol during the first trimester, due to the links between the consumption of alcohol and miscarriage (McAuley, 2009, National Collaborating Centre for Women's and Children's Health, 2008, NICE, 2008). Some women in this study reported following this additional guidance, pronouncing that they avoided drinking alcohol at the start of their pregnancy, because of the notion that the most risky time to consume alcohol during pregnancy was during the first trimester, as Paige expresses:

At the very beginning I didn't really drink anything at all...so I didn't drink anything at all the first three months, because, I think, that's the most important time for when the baby develops, and then I think when I was about four or five months pregnant I had the occasional glass of wine

Paige, 28, Edinburgh

Paige conforms to the recommendation to avoid alcohol in the first few months of pregnancy and clearly asserts her belief that it is best to steer clear of alcohol in the early stages when the baby is developing. This is reflected through her choice of lowering her alcohol consumption for the first three months of her pregnancy, until later on at around five month's gestation. Although not directly referencing this

recommendation as the reason for her behaviour, Paige indicates that women's choices around alcohol during pregnancy are influenced through this common perception that there is less potential for harm when drinking at the end of the pregnancy as opposed to the start.

It can be inferred from her original comment "I didn't really drink anything at all" that Paige didn't completely abstain from alcohol during her pregnancy, and instead made a concerted effort to lower her consumption levels. This citation interestingly highlights the importance of lay health discourse around consuming alcohol during pregnancy. Evidently Paige thought that her drinking later on in pregnancy was unproblematic and her individual awareness/knowledge process is important in her negotiation of the risks involved drinking during pregnancy. Paige also touches upon the theme of responsibility in her admission to having consumed alcohol during pregnancy, ensuring that she is not de-railing from the image of a 'good' mother. She does this by inferring that she made a good choice by abstaining from alcohol at the appropriate time not risking being labelled a 'bad' mother or showing herself to be putting her child at risk of harm. By highlighting that, she is making responsible/considerate choices for the health of her child by abstaining during the 'most important time' and 'when the baby develops'. The notion of risk was evident across some women's narratives in reference to the timing of alcohol consumption, with a perceived higher risk from drinking at the start of pregnancy, or in first trimester. The work of Douglas (1985, 1992, 1999) and Beck (1992) highlights how in modernity there has been a growing climate of risk awareness, with differing perspectives on risk put forward by 'lay' and 'experts'. This discourse on risk was also evident with women reporting to wait until their first scan to see if the baby was healthy. In this passage Catriona felt, that by having a scan, she could ensure that her baby was healthy, and this was important in her considerations of consuming alcohol. Catriona's belief conformed to this perception that drinking in the latter stages of pregnancy is of lower risk than drinking at the start.

I think I was probably in my mid, the middle months, I was feeling quite well, I think we'd had the scan and you know he looked fine and everything

Catriona, 29, Edinburgh

There was a clear relief that the baby was alright, as he “looked fine”, however there was also an embodied feeling that Catriona was healthy herself, as she describes “feeling quite well”. This added to her perception that consuming alcohol in the middle months of pregnancy was safer than earlier on in her pregnancy. The scan was spoken about in a comforting way as it was able to confirm that the child is healthy. This perception contrasts with the literature linking the scan to the dominance of the medical profession over women’s bodies as their ability to show you inside the body (Lupton, 1999b, Mitchell and Oakley, 1979). It was clear across the women’s narratives that many women actively found this process to be reassuring. The time prior to this scan was often spoken about as a period of anxiety and worry, before checking the baby was well. Once the scan had been conducted it appeared that women believed it to be safer to consume alcohol in the knowledge your child is okay. Skyla also highlights the lay discourse that alcohol should be avoided in the start of pregnancy and backs this opinion up by making reference to the previous government recommendations which were that a small amount of alcohol could be consumed.

Erm, I took the decision to drink no alcohol in the early stages, which at the time or prior to that had been the advice, and then very limited two glasses of wine maximum a week if that later

Skyla, 42, Inverness

Skyla does not define what she means by ‘early stages’, but suggests that this had been in agreement with the previous guidelines. She shows awareness of the change in guidance prior to her pregnancy without offering an opinion on this change and indicates that she chose to follow the old guidance and not the new approach of total abstinence. This ensures that Skyla is reflected upon as being a responsible mother who does listen to the guidance offered to her. Her choice could also be influenced by the fact that this was her second child, If she had followed the previous guideline for her first pregnancy, and had a healthy baby, it can be inferred that she perhaps felt that the old guideline ‘worked’ and wished to make the same choices. Again this reveals the importance that women place in lay knowledge in their decisions around health behaviours during pregnancy. Skyla’s dialogue in this extract does not focus on any potential risk to her foetus of consuming alcohol during pregnancy but

instead centres around the pleasure she receives from drinking (see Chapter 5 for a further discussion of the role of pleasure), yet doing so she simultaneously portrays herself as a responsible and restrained mother by referring to her alcohol consumption in terms of being ‘very limited’ and having a ‘maximum’ intake. She thus presents an image that she is controlled in her drinking even through her reporting of consuming two glasses of wine ‘maximum’ (see above quote) a week, is actually one of the higher reported levels of alcohol consumption during pregnancy in this study. Skyla once more alludes to the fact that consuming alcohol during pregnancy was a personal choice. It was her ‘decision’. These examples lend an indication of the significance that women give to the timing in their decision-making process about consuming alcohol during pregnancy. There is a clear perception here that drinking at the start of the pregnancy is potentially more harmful than alcohol drank later on in the pregnancy and this idea was touched upon by other women within the study who abstained until later in their pregnancy. Tina also reported waiting until later on in her pregnancy until choosing to consume alcohol:

In terms of alcohol and things I would say I was probably about five or six months pregnant when I started to have the very occasional odd glass of wine during my pregnancy....So I did have the kind of odd glass of wine at the end of the pregnancy

Tina, 32, Edinburgh

The lay discourse that women abstain at the beginning in the first trimester and that it is safer to drink later in their pregnancies was reflected through women’s admissions that when they did drink it was later in their pregnancies. Tina shows a consideration of the impact of timing when she consumed alcohol. By only consuming alcohol at the end of her second trimester she draws upon her own perceptions of when it is sanctioned to drink during pregnancy. Furthermore, Tina implicitly implies that she was restrained in her consumption and drank responsibly, reiterating her low level of alcohol consumption stating it was ‘very occasional’. There is also a nuance of responsibility as she consumed only the ‘odd glass’. This common theme that it was ‘safer’ to consume alcohol at the later stages in the pregnancy was also mentioned by Leah:

I was quite late in my pregnancy at that point so I knew it wasn't going to have any particular damage to my children

Leah, 39, Inverness

While also viewing alcohol as a treat, and its associated perception that it is not related with harm, Leah also shows an awareness that consuming alcohol 'quite late' in her pregnancy was less likely to cause her complications than if she had drunk earlier. She reiterates that her use of alcohol during pregnancy was low, explaining it to be a 'one off'.

Indicating that women abstained from alcohol when it was perceived to be a higher risk of harm, presents a discourse that it is acceptable to consume alcohol when it is safe to do so. For these women this was at the end of their pregnancies, and when they did drink they ensured they did so in a responsible way. The previously mentioned quotes are indicative of the way in which the women within this study constructed lay perceptions around the risks of drinking alcohol during pregnancy. There was a clear sense that timing was important in the consideration of consuming alcohol during pregnancy. All of the women also showed an attention to how they were "feeling" in making their decisions around consuming alcohol during pregnancy. By contrast to this, one woman in the study reported drinking on a few occasions throughout her pregnancy but avoiding alcohol completely at the end of her pregnancy:

Bucks fizz that's the one, so I didn't, I would say I drunk but I didn't drink through my pregnancy, I just had, I kept it to one or two special occasions and nearer the end of the pregnancy I definitely said no

Neala, 30, Edinburgh

Competing with the previous lay discourse that drinking alcohol at the later stages of pregnancy was safer, Neala, demonstrates a nuance that alcohol should be avoided at the end of pregnancy, her actions correlate with the findings of Ethen et al. (2009) who in the study of alcohol consumption before and during pregnancy, suggested that among women who chose to consume alcohol during pregnancy, the frequency and amount of consumption declined over the course of the pregnancy.

It became clear that some of the women in this study actually negotiated when it would be okay for them to consume alcohol during pregnancy, For Rhea in particular, alcohol was negotiated in line with her cycles of *In Vitro* Fertilisation (IVF). There were therefore periods where she avoided drinking because there was a possibility she might be pregnant, only to then drink again when her IVF had not been successful. As she explained:

Or if it was during the period where I might be pregnant, but I hadn't found out yet then I would, I would still have one or two drinks, but erm yeah I knew I could be pregnant so I didn't.

Rhea, 35, Edinburgh

Rhea emphasises that at time of the interview she is trying to conceive for a second child, and is still consuming a low level of alcohol consumption, therefore disregarding the current recommendation to abstain whilst trying to get pregnant. It is evident that through a pattern of self-regulation, she has carved out a cycle where she allows herself to drink and then abstains at particular moments when she is due to find out if her IVF has worked. Although implicit that she should avoid or lower her consumption, she continues to consume alcohol "very very mildly", thus, highlighting her self-surveillance and continual self regulation and responsible self. This also reflects the importance to her of choice, autonomy and responsibility. Reported alcohol consumption was more common through the middle months and at the end of pregnancy, with a few participants even joking that they consumed some alcohol at the end of their pregnancy in the hope that it may bring on their labour:

It must have been about two weeks before I was due and she had her boyfriend in watching a couple of DVDs and having a drink and she had some cider and I quite like, and err, I quite like cider that's usually what I would drink and erm she let me have a wee mouthful like "oh you never know it might bring on the baby" and we just laughed

Jennifer, 20, Edinburgh

There is no connotation within this narrative that drinking alcohol may be in any way a risk to the health of the child, having abstained from alcohol for the duration of her pregnancy. Jennifer was therefore very certain that a very small amount of alcohol

would cause her child no harm. This quote also highlights the conflict here that Jennifer experiences between her pre-pregnancy identity and the pregnant self/identity, as she adapts her health behaviours.

## **5.6. CONCLUSION**

Alcohol is part and parcel of our social experiences (The Social Issues Research Centre, 1998, Plant, 2008) and that to not drink means to risk being excluded. These experiences serve to highlight the way in which women in the UK self-regulate their alcohol consumption during pregnancy. The women in the study showed an awareness that by identifying themselves as women who drunk during pregnancy they risk being judged as irresponsible mothers showing an alignment with the idea that ‘the hand that rocks the cradle should not be a shaky one’ (Plant and Plant, 2006, p.30). Holloway et al. (2008) note that there is an absence of studies examining the everyday home drinking practices of a wide range of social groups who would not necessarily consider themselves to have an alcohol problem and this is important as ‘drinking at home can be an important part of home-based sociability’ (Holloway et al., 2008, p.538). We therefore need to consider the public versus private drinking spheres and the unintended consequences of where women are drinking during pregnancy. It is easier to regulate women’s behaviour in public contexts and drinking during pregnancy is socially regulated within the UK and Scotland, using social sanctions. In comparison drinking during pregnancy is more regulated within the US through licensing. In the States it is not as much about self-regulation, but the onus is positioned more on the choice of the individual server to serve a pregnant woman alcohol and on the establishment not to serve pregnant women alcohol and serving a pregnant woman carries penalties. In comparison in Scotland there are different regulatory regimes in place with voluntary codes within the Industry. In the UK the responsibility is on pregnant women to be self-regulating, this is shown through the legislation for warning labels on bottles. The focus on the discourses of individual responsibility is evident within Scotland as there are still expectations for how women should behave in public (Lyons and Willott, 2008). Women risk social disapproval and embarrassment by not following these.



## Chapter 6. Positive Drinking and Pleasure

‘Any discussion of the positives that drinking behaviour can bring are rare’

(Waterson, 2000b, p.2)

### 6.1. INTRODUCTION

The changing patterns of alcohol consumption in the UK has become a key issue of public and policy concern, with growing interest towards excessive consumption, the problem of ‘binge’ drinking and the apparent emergence of a ‘culture of intoxication’ (Measham, 2006, p.258). Consequently, there has been a dominance of problem orientated perspectives (The Social Issues Research Centre, 1998) around alcohol. The health and social consequences of problematic drinking are of particular concern, especially within particular populations such as youth and young adults (Kneale and French, 2008, Lindsay, 2009, Measham and Brain, 2005, Wilson, 2005). In addition the impact of the change in licensing to encourage a cafe culture within the UK, has led to an amplified interest in both ‘harmful’ drinking patterns and other social effects of the extension of public opening hours for licensed premises. Controversy also exists over any potential health benefits of drinking (Stockwell and Room, 2012).

As already discussed in Chapter 2 there has been a marked increase in the general trend for women’s consumption of alcohol, which has been met with anxiety, thus revealing the underlying gendered expectations and assumptions towards alcohol consumption practices, linked with traditional notions of femininity (Day et al., 2004, Ettorre, 1997, Holloway et al., 2009, Waterson, 2000b, Litman, 1986, 1975). As Beckman (1978) argues there is a stigma attached to female alcoholism, as women with alcohol issues are viewed as socially unacceptable because it interferes with their social role as mother and for women it is more of a social problem because it implies family instability (Ettorre, 1994).

The first person to use the notion that a double standard is applied to women’s alcohol consumption was Gloria Litman (1986) in the UK. Despite the rise of the ‘ladette culture’ (Holloway et al., 2009, p.822), it is apparent that strong gender

norms are still in existence, which see women's alcohol consumption as a risk to femininity, given the continuing connection of women as child producers (Waterson, 2000b). Women who consume alcohol, especially to a high level, are understood to be at risk of facing social disapproval (Ettorre, 1997, Lyons and Willott, 2008, Plant and Plant, 2006, ; 1987, Plant, 2008), and also are at risk of threatening their health. With this focus upon the ill effects of the overconsumption of alcohol it is not surprising that research has been preoccupied with conceptions of problem drinking and its associated harm. As a result, what is missing from the literature is a detailed examination of the role of 'positive drinking' (Ettorre, 1997, p.6) as the importance of pleasure in women's drinking practices is also under-researched (Coveney and Bunton, 2003, Ettorre, 1997, Fry, 2011, Heath, 1999, Klein and Jess, 2002, Lowe, 1999). The work of Ettorre (1992) was the first to address the notion of pleasure within the addiction field.

It is important that pleasure is made public; however, I am not advocating the consumption of alcohol during pregnancy, but suggesting the need to look at the pleasurable effects if we are to understand why women continue to consume alcohol. Pleasure could in this sense be seen as empowerment (Raymond, 1986, Ettorre, 1989), with women taking something for themselves. This chapter outlines the complex moral codes that exist around drinking during pregnancy, looking at alcohol as a social activity, the idea of 'positive' and 'negative' drinking as proposed by Ettorre (1997), the use of alcohol for relaxation during pregnancy and as a treat or reward. It will then examine its use for in-group identification and at special occasions, and finally will examine the role of guilt and shame around women's decision making surrounding alcohol consumption during pregnancy.

## **6.2. THE USE OF ALCOHOL FOR SOCIAL BONDING, INCLUSION AND FOR RELAXATION AS A TREAT OR REWARD**

The consumption of alcohol is a social activity, embedded within the culture of the UK. In many countries, socialisation and drinking have become intertwined (Fry, 2010). Work on the consumption of alcohol has a limited insight into its use within the private sphere, but the focus upon the social nature of alcohol has led to the turn to consider alcohol practice in the home and a small increase in attention towards the role of pleasure in affecting consumption levels. Despite this, very little has been

written on women's use of alcohol for enjoyment seeking and the use of alcohol for cultural identification, relaxation or the enhancement of food. Tensions exist in recognising positive drinking and the existence of pleasure in women's alcohol consumption, because of the gendered expectations that exist around women and alcohol (Ettorre, 1997, Waterson, 2000b). It is unsurprising, therefore, that a discussion of the pleasure women acquire from consuming alcohol during different life-stages, for example during pregnancy and motherhood, is also lacking given the strong negative associations between alcohol and motherhood (Plant, 2008, Ettorre, 1997, Waterson, 2000a, Day et al., 2004) and the increasing moral panic over women's alcohol consumption during pregnancy and negative outcomes such as FAS (Humphries, 1999, Paone and Alperen, 1998, Thompson and Kumar, 2011).

Graham (1994) has conducted work to understand why some people seek lifestyle damaging to health. The evidence suggests that light drinking during pregnancy is not associated with harm, as revealed by examination into the literature on women's alcohol consumption during pregnancy which reveals that there is still no evidence about the risk of low levels of alcohol consumption during pregnancy (O'Leary, 2012, Henderson et al., 2007a, 2007b, Chen, 2012, O'Leary and Bower, 2012). Writing on alcohol in pregnancy has especially negated the pleasurable aspect that alcohol can bring, not surprisingly because of the risks that are associated with heavy alcohol consumption and foetal health (Beattie et al., 1983, Chambers et al., 2006, Comasco et al., 2012, Ethen et al., 2009, Kesmodel et al., 2012, May et al., 2005, 2007, 2005, O'Leary et al., 2012). Pleasure has also, especially in the examination of drugs been linked to deviance (Henderson, 1993). The general concern in women's increased consumption patterns for alcohol within the UK has been accompanied by a resurgence of interest in women's alcohol consumption during pregnancy. This is expected given the introduction of the recommendation for total abstinence during pregnancy. The increased social concern attached to the use of alcohol during pregnancy has consequently resulted in the consumption of alcohol during pregnancy as a stigmatised activity (Ettorre, 2004, Francis, 2012, Murphy and Rosenbaum, 1994, Radcliffe, 2011b), with women who continue to consume alcohol feeling socially outcast and even, most extremely, being convicted of child abuse (Apolo, 1995, Armstrong and Abel, 2000, Daniels, 1993, Lisa, 1994). As Waterson (2000b) and Ettorre (1997) argue women who drink during pregnancy are probably the most

censored and stigmatised group. Because of the stigmas attached to consuming alcohol during pregnancy, there has been a lack of research with a focus to understand the use alcohol during pregnancy for a harmless pleasure.

In an examination of women and alcohol in a social context, Waterson (2000b) argues that the media emphasis (BBC, 2012, Foster, 2007, Laurence, 2008, Scotsman, 2007a) surrounding the effects of women's alcohol consumption during pregnancy 'promotes a view that all drinking in pregnancy is harmful'. This viewpoint has been exacerbated by the promotion of a recommendation for total abstinence that is now in place in the UK. Despite the potential stigma associated with drinking alcohol during pregnancy, participants within this study did however refer to the importance of pleasure in their choice to consume alcohol during pregnancy.

### ***The importance of the idea of 'Positive' and 'negative' drinking***

The focus upon alcohol related ill-health is unsurprising; nonetheless there has been a call to improve our understanding of how women use alcohol in their everyday lives (Waterson, 2000b). In their findings from looking at alcohol and femininity, Day et al. (2004) argue that women's drinking is commonly constructed in negative ways; to allow for a better understanding of how women use alcohol for pleasure this needs to be readdressed. Heath (2007, p.S72) argues that the consumption of alcohol is associated with a wide range of positive associations such as 'celebration, feasting, sociability, in-group identification and social support, relaxation, the enjoyment of food, and other aspects of social well-being'. It is important, therefore, that these are recognised if we are to further understand the reasons why women chose to continue to drink alcohol during pregnancy.

The pleasure gained from drinking is evident in the reasoning for consuming alcohol, within the accounts of individuals who consume alcohol at high or low levels. Pleasure, also influences women's consumption levels even across social groupings who would perhaps not define themselves as having an alcohol problem, as women partake in what Ettorre (1997) defines as 'positive drinking'. According to Ettorre (1997) the concept of 'positive drinking' implies that women's use of alcohol can be experienced in a positive way, focusing on moderate levels of alcohol consumption. Ettorre (1997) contends that the consumption of alcohol is a pleasurable experience,

acting as a social lubricant to aid relaxation. In comparison, ‘negative drinking’ as defined by Ettorre (1997) involves drinking to excess to ‘kill’ or ‘medicate’ feelings, and frequently results in women being harmed by their over-consumption. I am going to use this framework to suggest that pleasurable drinking, forms part of positive drinking and is therefore a controlled form of drinking, where women drink for pleasure but monitor and limit their own consumption levels.

As already discussed, it is to be expected that this concentration upon the harmful effects of alcohol and alcohol problems has overshadowed any research examining positive drinking or any sense of pleasure that may be derived from women’s use of alcohol. It is necessary, therefore, to recognise some of the alcohol-related benefits that exist which may contribute towards an enhancement of our quality of life (Heath, 2007) and influence women’s alcohol consumption levels. It is imperative, therefore, that we consider alcohol consumption in terms of both these positive and negative consequences in order to create a balanced view of the normal drinker (Plant, 2008).

A number of participants in this study articulated the pleasure they gained from ‘positive drinking’ before they were pregnant, or after they had given birth. They explained the ways in which their consumption of alcohol facilitated their social interaction and formed part of their pre-pregnancy identity and the pleasure which they derived from this. Kylah, for example, saw alcohol as a ‘social lubricant’ (Emslie et al., 2012, Ettorre, 1997), describing its use as a way to “let hair down”, “relax” and also to “get out”. For Kylah, becoming a mother at a young age had clearly been an isolating experience, which led to her life becoming more privatised and more home-centred as she reported a general feeling that she missed out on nights with her friends:

It would be sort of every few weeks I’d maybe go out with my friends and have a few drinks, erm just to have just to let my hair down, after having the wee one and being stuck inside...I think it was just sort of a way to relax just to get out and see my friends after having been stuck at home with the wee one and not seeing anyone

Kylah, 25, Inverness

Kylah articulated that drinking and socialising were a “way to make myself feel a bit better” after becoming isolated as a young mother. Alcohol was very much a part of her pre-pregnancy social identity, the use of which enabled her to “go out and chill” and “let go of worries”. Kylah experiences positive drinking. She does not need to drink in excess to feel good; however consuming alcohol is for her a way to relax and an enjoyable experience. Her drinking is, thus, what Ettorre (1997, p.7) describes as a ‘social tool’.

It is essential that within an examination of women’s use of alcohol it is acknowledged that positive drinking exists. This is not to negate the fact that ‘negative drinking’ also exists, but to recognise that as Heath (2007) contends, for most people drinking is a deliberate act, which people do for their own enjoyment. One finding of this research was that pleasure is key to positive drinking (Ettorre, 1997) and its influence over women’s alcohol consumption patterns, even in pregnancy needs to be acknowledged.

### ***The use of Alcohol during pregnancy for relaxation***

It is evident that alcohol has strong links to the women’s identity, especially her pre-pregnancy identity, where to drink alcohol would be considered a normal and social thing to do. Notions of pleasure, and alcohol for relaxation existed in the reasons why women consumed alcohol before pregnancy, as Paige described:

Before I got pregnant I used to drink, (pause) erm a glass of wine maybe every other evening or so and it seemed a natural end to the day

Paige, 28, Edinburgh

Alcohol is therefore a firm part of women’s routines and ways of relaxation. It was an ordinary and a usual part of their lives pre-pregnancy. This trend continued for some women into their pregnancies.

A number of participants who consumed alcohol during pregnancy articulated the pleasure that they gained from it. Their low level of consumption and their attitudes towards alcohol conformed to what Ettorre (2007) frames as positive drinking. An examination into the reasoning’s given by women for their consumption of alcohol during pregnancy, finds the benefits of drinking for social interaction, to relax, and

enjoyment to be of importance. The findings correlate with those of Rolfe et al. (2009, p.329) who in a discourse analysis of heavy drinker's accounts from women emphasises that 'drinking is constructed as a source of enjoyment, relaxation and reward'. Several women who consumed alcohol during pregnancy pointed out the positive effects that can be derived from alcohol. Principally alcohol was used by some women as a method of relaxation. As Skyla described:

Very limited two glasses of wine maximum a week if that later on erm  
because it can be quite relaxing if you're a bit wound up about things

Skyla, 42, Inverness

Pregnancy is recognised to be a highly stressful time for women, and being able to relax with alcohol was a continuation of a behaviour which they saw as part of their selves. This relates to the way in which women have a change in identity when they become mothers (Phoenix et al., 1991, Miller, 2005). Indeed, several of the mothers whom I spoke to in this study made reference to the relaxing effects of alcohol consumption in their reasoning for continuing to consume alcohol during pregnancy. Catriona expresses how alcohol was used as a relaxation technique for her during pregnancy. Recognising that she can be over anxious about things, she wanted a glass of red wine to enable her to resolve her stress and worry and feel more relaxed.

I am sort of aware that I can be over the top, you know I can probably be  
a bit neurotic and I remember fancying a glass of red wine

Catriona, 29, Edinburgh

From the participant's perspective, the use of alcohol was medicinal as a way to relax and unwind during a period in their life which was predominantly stressful. It was evident that despite the social expectation that women should abstain from alcohol during pregnancy, some women still desired consuming alcohol to some extent.

### ***The consumption of Alcohol during pregnancy as a treat or reward***

Some of the participants interviewed reported consuming alcohol during pregnancy because it was a pleasurable activity and something they enjoyed doing. In this respect alcohol is a luxury which tempts women, as Zoe remarked "the temptation is

too great”. Alcohol, in this sense is considered a luxury for pregnant women. The most predominant way in which pleasure was derived from women’s alcohol use during pregnancy was through women’s enjoyment of alcohol, for both the ‘simple enjoyment of the taste’ (Rolfe et al., 2009, p.329) and their use of it as a treat or a reward.

So I thought that erm that was going to be my one treat in pregnancy,  
which I was sure wouldn’t do any harm at all

Leah, 39, Inverness

It is clear from Leah’s statement that women did not just naively seek pleasure from alcohol; instead they were aware of the risk of choosing to drink during pregnancy, but because their drinking was not a ‘problem’ for them, they deduced that they could have it as a treat. Because Leah thought that she was a low level drinker she did not associate any harm with her alcohol consumption. This aligns with the evidence behind low levels of alcohol consumption during pregnancy as being unproblematic (Kelly et al., 2009, 2010). Harm was therefore negated by the indulgence that a small amount of alcohol carries. It was evident that the main reason why many of the women, who did consume some alcohol during pregnancy, did so because of the pleasure they sought from it. Despite this, they still restricted and limited their consumption, in order to be responsible mothers, revealing an awareness that drinking too much could be risky. As Zoe reported:

Obviously as much as you love your wine you know it’s probably not a  
good idea to have too much of that, so like, you know the very little that  
you get is just enough

Zoe, 42, Edinburgh

It is evident that Zoe feels drinking alcohol too much in any scenario is not a good idea, because of the potential harm it could bring. This was supported through her idea that everything was good in moderation. Zoe portrays the generalised idea that drinking excessively, while pregnant, is “probably not a good idea”, and indicates she sees this as a recognised fact. The pleasure that she gets from consuming alcohol is manifested through the language she uses, the word “love” and that “very little is just enough”. Zoe demonstrated how she would therefore rather consume some



alcohol, at a low level for pleasure than abstain completely. For Zoe this is a rational choice, which she sees as normal for non-problematic female drinkers. This coincides with the conclusion of Rolfe et al. (2009) who argued that the construction of drink as a pleasure and as a choice may normalize women's drinking.

The impact of pleasure in women's choice around alcohol consumption during pregnancy was clear. However the role of pleasure was also important across other health-related behaviours during pregnancy for example, smoking. For Mya, smoking during her pregnancy, whilst on holiday was also perceived to be a 'treat'. This notion of a treat was important, as she reported abstaining from smoking at all other times during her pregnancy.

I think just one cigarette a night was my, my sort of wee treat

Mya, 21, Edinburgh

This use of a cigarette as an indulgence signifies the impact pleasure had on women's choices around health-related behaviours during pregnancy. Mya also revealed that she chose to smoke one cigarette a night whilst on holiday at an all inclusive bar as a treat rather than to have a drink. This is interesting given that research shows smoking during pregnancy is linked to increased harm (Benjamin-Garner and Stotts, 2013, Fingerhut et al., 1990, Giglia et al., 2007, Graham, 1976, Holdsworth and Robinson, 2008, Lawrence and Haslam, 2007, Oaks, 2001, Scotsman, 2008b), yet there is no evidence to say that light drinking during pregnancy is harmful (Kelly et al., 2009, Kelly et al., 2010, Knupfer, 1991, O'Leary et al., 2007, Henderson et al., 2007a, Henderson et al., 2007b, Chen, 2012, O'Leary, 2012). This was also evident in women's choice to consume alcohol whilst breastfeeding as Neala reported that she:

I drank during breastfeeding 'just purely for celebration'

Neala, 30, Edinburgh

The role of pleasure, therefore, needs to be considered more widely within the choices that women make towards not only alcohol but other health behaviours during pregnancy. As Armstrong and Abel (2000) argue in their examination over

the moral panic of FAS, societies have different perceptions of risk from alcohol and other behaviours such as smoking.

*The women's choice to only drink alcohol during pregnancy on special occasions*

Crucially, it was evident that the social nature of alcohol consumption was important in a woman's choice to consume alcohol during pregnancy. There was a clear sense that by drinking, women could maintain an active role in social occasions such as weddings, thus reflecting the argument from the study into moderate drinking by Heath (2007, p.571) that drinking is a 'quintessentially social activity'. The primary occasion where women recounted consuming alcohol during pregnancy was at weddings; other occasions which were perceived to be acceptable to consume alcohol were family occasions, such as birthdays, New Year and Christmas. These events were described by the women as 'special', and implied that consuming alcohol was legitimised through the act of celebration. As Neala make clear:

Just one or two on the very odd occasion which was the special occasion which obviously crossed over erm Christmas and New Year. So I had err just one or two glasses of champagne at occasions like birthdays Christmas even

Neala, 30, Edinburgh

It became evident that weddings are events where it is culturally and socially acceptable for pregnant women to participate and be part of the celebration by consuming a small amount of wine or champagne. In these circumstances alcohol was viewed as an 'acceptable social drug' (Ettorre, 1997, p.16) and the potential harm that alcohol could cause was not mentioned. Consuming alcohol in these circumstances was therefore viewed as acceptable and was tolerated.

And I thought one glass of champagne because it was at the wedding, I thought I was going to toast the bride and groom, and my goodness me this glass of champagne lasted me the entire day and night

Leah, 39, Inverness

Under these circumstances, the women's alcohol consumption is defined as 'positive', because of the nature of the way in which the alcohol is consumed, in celebration. The pleasure which women derive from it is consequently acceptable and it appeared to be an occasion where women could not be stigmatised for drinking during pregnancy. There is also a perception here that these 'special' occasions are not everyday occurrences, and the type of alcohol consumed, primarily champagne, is seemingly a 'special' drink. It is classed in its nature and therefore does not conjure up the same images of alcohol related harm that other harder drinks such as spirits do.

Erm the champagne was really special

Yvette, 35-44, Edinburgh

Champagne is certainly not a drink usually associated with negative drinking or alcohol-related harm. The importance of the type of alcohol women consumed during pregnancy is developed later (see Chapter 7). Attitudes, therefore, appear more liberal towards women drinking during pregnancy at 'special' social gatherings, where the type of alcohol is more luxurious. In this context the pleasure of drinking is recognised as a suitable justification for drinking during pregnancy. The attitudes of the women in the study towards alcohol therefore aligned with those of Holloway et al. (2008, p.534) in their examination of English alcohol policy, who consider 'drinking as a broad-ranging social practice, rather than as a necessarily problematic behaviour'. The women within the study, who consumed alcohol during pregnancy at weddings and other social activities, comply with the notion of 'positive drinking', as they seek pleasure from alcohol and avoid its negative consequences. In these situations women's consumption patterns are not subject to the same scrutiny as other locations. It is important to consider that the women's alcohol consumption during these occasions remained low and this reflected the participant's idea that this level of consumption was unproblematic and not a risk to their child.

***The use of alcohol for in-group identification and the importance of pre-pregnancy drinking practices***

In this manner alcohol consumption during pregnancy can be seen to ensure in-group identification for women, at a period in their lives, where women can feel isolated because of all the changes taking place. This is highlighted by Olivia, whose choice to consume alcohol at a wedding was influenced, by the isolation and difference she felt whilst pregnant at a wedding. At five months gestation, Olivia felt different to the other guests at the wedding due to her bodily changes, and consuming a small amount of champagne cheered her up and enabled her to feel better about herself and included. This serves to reflect the wider ways in which Waterson (2000b) argues that women's bodies are policed.

Half a glass of champagne, erm it was my husband's, erm cousins wedding and I felt quite miserable because I didn't not have a proper bump. I just looked really fat, and everyone looked lovely and all dressed up and stuff

Olivia, 32, Edinburgh

It is clear that drinking during pregnancy is perceived by some as risky and problematic but for the women whose drinking patterns fitted into positive drinking, their low level consumption during pregnancy meant that their choice to drink, for them was a pleasurable one. Their pre-pregnancy consumption patterns, affected their choices around alcohol, as identifying themselves as 'positive' and low to moderate drinkers, they believed that they therefore had more control over their alcohol choices.

Because I wasn't a big drinker, it wasn't like I was just dying for a drink as such, I think that's how I justified and rationalised it for myself' .... I don't think that I attached much emotion to it I just think that I really fancied a glass of red wine.

Catriona, 29, Edinburgh

Consuming alcohol during pregnancy was justified because these women did not identify as 'problem' drinkers. Having a healthy attitude towards alcohol, prior to

pregnancy therefore influenced women's choices around alcohol during pregnancy. Catriona demonstrated the importance of pre-pregnancy drinking habits and their effect on the pleasure she gained from drinking during pregnancy. Pleasure as a reasoning for drinking during pregnancy was significant for these women and was identified as pure and harmless. As Leah demonstrated

And also it wouldn't trigger me starting to drink during my pregnancy it was just a one off because of the occasion, and I enjoyed it, immensely

Leah, 39, Inverness

If women were identified as low level and therefore unproblematic drinkers before they were pregnant, their low level consumption during pregnancy was rationalised as acceptable. Leah demonstrated that her consumption was limited and would not lead to over consumption. Women who were not dependent on alcohol could, as a result, consume alcohol during pregnancy and derive pleasure from it, without feeling that they would be stigmatised for their choices. Although pleasure was evidently an important reason why women chose to drink during pregnancy, this does not mean women did so uneducated or without considering the potential risks it could bring. Instead the participants were aware of messages that surround the consumption of alcohol during pregnancy, as Catriona explained:

But I suppose rationally that if there's an extreme level if you drink a lot that's known to damage the foetus then I suppose by that argument that drinking a small amount may damage it a little bit, that would be my rationale, so that is why I tended to stay off, but I suppose sometimes I did just really fancy it

Catriona, 29, Edinburgh

Catriona was aware of the potential harm that alcohol could cause to her unborn child, but revealed that this was only likely to occur to women who have drank at 'extreme' levels. As she found pleasure in consuming a low level of alcohol she wanted to continue to drink on a few occasions. She rationalised that there may have been a slight risk of harm from a low consumption level but that her desire for alcohol outweighed the risks. Her choice is influenced both by notion of risk and also pleasure. Knowing that she does not have a problem with alcohol helped her

with legitimising her choice. One woman whose experiences differed to this was Elsie, who recognised that because of her previous alcohol dependence that she was best abstaining from alcohol altogether whilst pregnant. The pleasure and the social nature of alcohol was also evident as women recounted it as being something that they looked forward to doing once they had given birth. As Jennifer described:

So I think in my whole pregnancy I had two mouthfuls of cider. But not because I felt like I needed to, or I was pressured into it, but purely because I had been what about thirty-eight weeks and I was just, I wouldn't say I was craving it, I was just saying that I was looking forward to having a nice drink

Jennifer, 20, Edinburgh

Jennifer highlights how her consumption was not influenced by others. She wasn't pressurised into consuming alcohol during pregnancy and that she does not have a problem with drinking, as she did not 'need' to do it. However she was looking forward to it, so chose to drink. Despite highlighting the consumption of alcohol during pregnancy, mothers were quick to highlight that the frequency of consumption of alcohol during pregnancy was 'occasional'. This again only serves to depict the glass of wine in a meal setting as a luxury and a pleasure, consequently a special thing to do and something which although consumed is still done so in a restricted manner.

### **6.3. THE IMPORTANCE OF GUILT IN WOMEN'S DECISION MAKING PROCESS AROUND THE CONSUMPTION OF ALCOHOL DURING PREGNANCY**

In their study, Lyons and Willott (2008) found that women's drinking was linked to pleasure and fun, however drunk women were positioned as deviant. Despite the theme of pleasure in women's reasoning for consuming alcohol during pregnancy, it was evident that because of the discourse that women should abstain from alcohol during pregnancy, some women experienced feelings of guilt over their alcohol consumption. Although Yvette actively questioned and challenged the different recommendations given to women, and held reservations over how true the guidance was in terms of risk (see Section 5.5 for a more detailed discussion of this finding), Yvette also mentioned feeling guilty. She interpreted this as "bizarre" as she

recognised the role that alcohol had within her social life during pregnancy, and its benefits as a way to relax and de-stress, something that she viewed highly valuable when pregnant. Yvette describes her feelings and associated guilt:

It is part of my social life (alcohol) and I don't think it really helped with stress levels because it is really unnatural not to have, I felt guilty then sort of having a few glasses of wine and things, which was bizarre for the ways that you do stuff

Yvette, 35-44, Edinburgh

Central to her recognition of alcohol as a pleasure, Yvette struggled with the way in which as a pregnant woman, drinking alcohol was now perceived as a guilty pleasure. This was something which she was aware that some people thought she should avoid and that consequently she might be stigmatised for. Subsequently she struggled with her own decision making and justification for drinking. It is possible that this guilt was informed by awareness that although drinking was her choice and she resisted the recommendation to abstain, she could be potentially judged harshly and as a 'bad' mother for her behaviour by others. Other women in the study recognised the pleasure that you would get from drinking but demonstrated evidence of an internal debate and feelings of guilt. This inferred a perception of the maternal conflict of doing something for one's own pleasure versus the potential risk this could bring to the child. Speaking whilst pregnant, Kylah inferred a sense of guilt which she felt around consuming alcohol during pregnancy:

Erm now and then you feel like just sitting down with a glass of wine and have a drink just to relax you, but no I don't, not at the moment I've sort of gone off it in a way, which is fine

Kylah, 25, Inverness

***The associated Guilt of drinking alcohol whilst pregnant but before they knew that they were pregnant***

The impact of the call for abstinence from alcohol during pregnancy, clearly served to confuse women further around what was the right decision to make around alcohol. The women who reported receiving inconsistent messages on what they

should do about their alcohol consumption during pregnancy (see Chapter 4 for a further discussion of this) led to further guilt, worry, anxiety and stress if they had unknowingly drunk during pregnancy. Hermione demonstrates this stating that after meeting her doctor she:

I just left erm I was just very confused and worried

Hermione, 37, Inverness

Having consumed alcohol during pregnancy but before they were aware that they were pregnant led to increased concern and anxiety. The women were therefore worried in case they may have caused damage to their child. Many women spoke of how they agonised over having drunk too much before they knew they were pregnant, and were worried about the harm that this may have caused. Women who had also consumed alcohol before they were aware they were pregnant did mention a feeling of guilt, but at times this reflected their own frustration and feelings that they had been careless, or as Rhea pointed out ‘irresponsible’. This reflected that across the women interviewed there was a general awareness of the risks that the heavy consumption of alcohol during pregnancy presents. As Jennifer explains;

I had drunk a lot again and he (the doctor) just said that, erm, I can’t even remember him really saying anything in particular, like yes that will be a bad thing or you don’t know what’s going to happen, he just said that, like I didn’t know, like I didn’t know I was pregnant, so at the time I wasn’t doing anything bad

Jennifer, 20, Edinburgh

Her drinking here was framed as acceptable because she was unaware of it. If she had intentionally drunk in pregnancy this may have been different. This situation proved to be one of the occasions where participants actively sought medical guidance over their alcohol consumption. Jennifer clearly felt very paranoid about her over-indulgence in alcohol before she knew she was pregnant. Despite this she felt that her doctor’s responses were somewhat unclear and although he did offer some guidance in recommended units of consumption if she turned out to be pregnant, she felt that she did not receive what she termed “proper advice”. Jennifer was not the only participant who recalled going to the doctor ‘paranoid’ but then received a



message not to worry as the majority of women who experienced this were informed that most women drink before they realise that they are pregnant.

I went to the doctor paranoid because I had been drinking that day more than I usually do, just it was just a sort of one off thing, and the doctor said don't worry everyone does that before they knew. And also it was my sister's wedding two days later, so the doctor said not to worry and just have a wee glass of champagne at the wedding and not be too paranoid about it

Wendy, 33, Edinburgh

This anxiety that women experience over the consumption of alcohol before they knew they were pregnant, is clearly worsened through the introduction of a recommendation for abstinence. When women feel they perhaps overindulged, this idea that they should potentially abstain altogether during pregnancy led to worry about the potential negative consequences. Although the women did seek medical assistance because of their worries that they had consumed too much alcohol before they knew they were pregnant, the advice they were given by doctors that drinking a small amount was acceptable and that they had probably nothing to worry about did not sit with the current recommendation for abstinence. This was especially evident as Wendy's doctor suggested not to worry and to have a glass of champagne, even highlighting that her concern was not legitimate but that she was being too 'paranoid'. This added to the ways in which women were suspicious of the recommendation for abstinence and questioned it (for a further discussion of this see Chapter 4). In women's various interactions with doctors and other clinically trained staff it was evident that women sought information on what 'safe' level of alcohol consumption exists during pregnancy. Yet only two women in the study mentioned being asked about their alcohol consumption levels at a midwife appointment.

I think you have these erm, you have to answer these questions at the, for the midwife and things, and they asked you about your alcohol and I ticked occasionally because I probably had about ten or fifteen drinks

like the whole time that I was pregnant, perhaps, maybe not even that much maybe less than that erm

Rhea, 35, Edinburgh

Yvette also recalled being asked about her alcohol consumption levels during pregnancy:

She asked me about drinking and I said “oh yes I’m drinking less than I used to, but I’m still dinking reasonable amounts” ...and she said “oh you shouldn’t even be having that in a month, you shouldn’t be drinking so often” and I though oh all right, it wasn’t quite what I had expected

Yvette, 35-44, Edinburgh

It is evident here that for some women, they felt that they could continue with positive drinking for pleasure during pregnancy. Yet some women worried when they may have consumed an excessive amount of alcohol before they realised that they were pregnant. Guilt was therefore important. This therefore demonstrates an awareness of women that although for some alcohol is still perceived to be acceptable to consume during pregnancy, this is only at very low levels which actually is what the scientific evidence suggests and what the guidance prior to the recommendation for abstinence was.

***The Guilt or shame that women felt they should abstain and how this links to the responsibility of the ‘good’ mother***

Other women also touched upon the discourse that they should abstain from alcohol during pregnancy, Mya abstained citing the perceived guilt she would expect to feel if she consumed alcohol as her main reason for abstaining. This implied guilt, expresses an awareness of the fear of harming her child. Their choices around alcohol consumption during pregnancy were influenced by contrasting a behaviour ‘for you’ versus ‘for your foetus’. Mya implies that she would feel terrible for choosing to drink alcohol purely for pleasure whilst risking the health of her unborn child; she expressed that she “couldn’t do it”. A number of participants articulated this discourse that you should avoid alcohol during pregnancy. As Kylah stated:

When I was pregnant of course I didn't drink

Kylah, 25, Inverness

It is evident therefore that there are competing discourses prevalent around women's alcohol consumption during pregnancy. A normalisation of abstinence may have led to the lay health belief that you shouldn't drink. Kylah for example emphasises her decision around the moral discourse of being a 'good' mother, indicating that she made the right choice for her child and acted responsibly. This therefore highlights the lay importance women still attach to being a 'good' mother.

As soon as you're pregnant you kind of feel this guilt if you're doing things that you're not meant to do

Paige, 28, Edinburgh

'Good' mothers were therefore responsible in their health choices or were made to feel guilty or shamed. This guilt or shame was therefore a tool which prevented them from conducting certain health behaviours like consuming alcohol during pregnancy as Mya explains:

And drinking, I never touched a drop at all when I was pregnant, like I, like I say, it was guilt more than anything I just couldn't do it

Mya, 21, Edinburgh

Yvette highlighted a sense of surveillance, saying that she felt like people were 'watching me' to ensure that she acted like a 'good' responsible mother. She emphasised the feeling that there is a pressure to not drink alcohol, indicating that women are made to feel guilty if they do consume alcohol, inferring therefore that alcohol is something women should avoid and she had a clear awareness of the way in which women are targeted through this surveillance:

And I do feel that you know you are made to feel guilty if you have a sense of responsibility, and I am always going to try to do the best by her. So I'm not going to beat myself up if I have a few glasses of wine... I suppose in my case I've been quite responsible about it

Yvette, 35-44, Edinburgh

Yvette asserts that her own sense of responsibility outweighed any potential stigma associated with consuming alcohol during pregnancy; in this sense, she did not see her alcohol consumption in any way as detrimental to her ability to be a 'good' mother. She resisted this notion that she should be made to feel guilty when she argues she is being a responsible mother. In this sense consuming alcohol does not seem dangerous and does not conflict with the 'good' mother ideology (Hunt et al., 2005, Miller, 2005, Phoenix et al., 1991, Rothman, 2000, Shelton and Johnson, 2006). Wendy also made reference to this way you can be made to feel guilty if your mothering is not in line with the ideal 'good' mother, however she insisted that she had not felt that way:

So I haven't felt anyone, anyone judging me, but if you were to listen to the media and listen to all the things that you should be doing, then there's a lot you could feel guilty about

Wendy, 33, Edinburgh

Both these quotes give an insight into the way in which pregnant women feel that they are being targeted and being judged as 'good' enough mothers. Responsibility was important and this also impacted upon the idea that women were responsible if their alcohol consumption aligned with the positive drinking ideal. There is a strong sense that women are regulated by their sense of guilt, they are controlled by it, in that if they were 'good' mothers, they would not do any behaviours which they would ultimately feel guilty about. For most women there was none or very little associated guilt with a low level of alcohol consumption, or for where drinking alcohol was done for the purpose of pleasure. This aligns with the finding of Waterson (2000b, p.31) who examined women and alcohol in a social context and concluded that 'many women reduce their alcohol intake during pregnancy. But rather than a measured response to scientific health advice, this is more likely to be out of deference to taboos against drinking whilst pregnant, or because of a generalised sense of responsibility to prevent any harm to their child'. This idea of responsibility was reflected within this study. It can also be demonstrated that the pleasure of drinking is perceived to be less threatening than other potential risks. As Giddens (1991) argues taking risks is part of everyday life.

## 6.4. CONCLUSION

As Ettorre (1997) has noted it is important that we make women's use of alcohol visible in areas which have not always been examined. Pleasure emerges as a strong theme from this study, as was one of the main influences over women's consumption of alcohol during pregnancy. By giving credence to the pleasure that women get from consuming alcohol during pregnancy it is not suggesting that the pleasure in drinking outweighs the risks and therefore that all women should consume alcohol during pregnancy; instead it reveals how it is important to consider the impact that pleasure may have to any recommendation made to women and the potential related benefits from consuming alcohol. Alcohol, was still a desired substance for some women, who spoke of 'fancying it', and for some women abstaining was even something which women needed to make a concerted attempt to abstain. This serves to highlight again the way in which alcohol has become so culturally and socially acceptable in Scotland. It is part and parcel of daily life, therefore to be without it can seem unusual.

It is important that we recognise that women have individual and different attitudes towards alcohol, which have been informed by their alcohol career, their family culture and other experiences with which they may have grown up with. Recommendations made to women therefore need to take into account the ways in which alcohol use is socially constructed in Scotland. Any recommendation made to women should therefore take into account the social nature of alcohol consumption and the role of positive drinking amongst women's lives, therefore, recognising the harmless pleasure which is derived from its use.

We therefore need to carefully consider what promotes health seeking behaviour, and if we are to label women who consume one glass of alcohol during pregnancy as not health seeking? In this sense it is evident that the women themselves are performing a balance of risks, weighing up the pleasure gained, from positive drinking versus the potential hazards that exist from consuming alcohol during pregnancy.

For some women their pleasurable drinking behaviour is 'a symbol of resistance or freedom' (Waterson, 2000b, p.118) to the surveillance which is placed over women. To ensure that they conform to the 'good' mother ideology women are made to feel

guilty; alternatively some women reported resisting this ideology as they would not be made to feel guilty when they see themselves as responsible mothers. This serves to highlight the complex moral codes that exist around the consumption of alcohol during pregnancy, and the important role of gender. Gender is important as a theme as it is evident that women's entitlement to pleasure seems to require justification (Rolfe et al., 2009), more than that of their male counterparts. The entitlement to pleasure did require justification, as women justified their alcohol consumption levels through the pleasure they received from it; they still had to warrant a reason for this. By asserting that they were 'good' mothers, women tried to preserve their status, through the use of responsibility, ensuring that although they consumed alcohol during pregnancy they did it responsibly in small amounts, and not for general everyday pleasure but for more of a luxury. Despite some women refusing to feel guilty over their health choices, guilt was still apparent as a theme, as it was the reason why some women did not consume alcohol during pregnancy, or was one of the reasons why they regulated their health behaviours.

## **Chapter 7. The Feminisation of Wine and the Acceptability of Certain Types of Alcohol**

‘Thus while gender may influence drinking alcohol, drinking alcohol may also be seen as a way of ‘doing gender’ and accomplishing both traditional and non-traditional gender identities’

(Lyons and Willott, 2008, p.696)

### **7.1. INTRODUCTION**

In the above quote Lyons and Willott (2008) highlight how drinking alcohol may be seen as a way of doing gender, it is therefore important to use a gender sensitive perspective when looking at alcohol consumption. As examined in Chapter 2, traditional approaches to alcohol studies have routinely come from a masculine standpoint, ensuing that women’s alcohol consumption has been viewed as a social problem that needs to be controlled by alcohol professionals and predominantly men (Ettorre, 1992). Consequently women’s experiences surrounding alcohol have historically been marginalised; however, recent work has served to give further understanding to women’s drinking experiences (Ettorre, 1997, Waterson, 2000b). Popular interpretations of women’s alcohol consumption continue to be closely entwined with traditional ideas about femininity and this has led to widespread ambivalence to women’s drinking (Day et al., 2004, Ettorre, 1997, Rolfe et al., 2009, Waterson, 2000b) accompanied by a moral panic (Cohen, 2002). Measham (2002) argues that drug use is mediated by gender, and that drinking can be used as a way to establish traditional and non-traditional femininities.

Gender dynamics of alcohol use have historically existed as RÚDÓLFSDÓTTIR and Morgan (2009, p.493) argue, women and alcohol traditionally have been considered ‘unsuitable bedfellows’. Cultural associations exist between masculinity and alcohol consumption (Iwamoto et al., 2011, Lyons et al., 2006) lending to the consumption of alcohol by women to be perceived as unfeminine and deviant, while in comparison, male drinking is sanctioned and encouraged as a customary activity and demonstration of masculinity (RÚDÓLFSDÓTTIR and Morgan, 2009). In her work on women and alcohol, Ettorre (1997) uses the term ‘overdrink’ to get away from using the term drunk, as an attempt to try to take away the moral judgements from women.

I too will use this term to describe women who drink beyond sensible drinking guidelines as purported by the Department of Health (NHS National Services Scotland, 2010) (see Chapter 1 for a definition of sensible drinking guidelines). This double standard between men's and women's alcohol consumption sees women, especially those who drink to excess and over recommended limits, being perceived more harshly than their male counterparts. These differing judgements reveal how women's alcohol consumption continues to be deeply linked with women's position in society (Ettorre, 1997) as women who overdrink are alleged to be threatening traditional female roles and consequently face extreme social disapproval for doing so. Women's control over their own responsibility is placed at risk by the consumption of alcohol which has consequences for how we examine the role of women's alcohol consumption during pregnancy.

As Plant (2008) examines, alcohol has become increasingly more accessible and more acceptable for women to drink, with increases in women's drinking being reflective of women's changing social positions (Lyons and Willott, 2008). The introduction of designer drinks in the late 1980s specifically tailored towards the female market (Waterson, 2000b) combined with the increase in alcohol being designed, packaged and marketed specifically to appeal to women (Otto, 1980) has led to the rise in alcohol as a lifestyle product (Rúðólfssdóttir and Morgan, 2009). The wealth of advertising and marketing of alcohol as 'women-friendly' has increased alongside specific drinks being created specifically targeting the women consumer (Ettorre, 1997). There appears to be a dissonance between the advertising of alcohol and the way in which women as alcohol consumers are now targeted compared to the guidelines that women are given around alcohol consumption in general. Although in recent years alcohol advertising has become aimed at responsible drinking (Ettorre, 1997, Rúðólfssdóttir and Morgan, 2009), there has still been increasing pressure for women in general to lower their alcohol consumption in Scotland. In their examination of how alcohol is portrayed in the media, Lyons et al. (2006) found that drinking is constructed as a normal everyday social activity entitled the normalization of drinking. Alcohol now plays a crucial part in popular media as an accepted part of women's social life and appears throughout many women's glossy magazines and television programmes as an acceptable substance. However, Ettorre (1997) argues that at the same time as this alcohol advertising is aimed at



encouraging women to drink, a woman who drinks too much is perceived as being feeble and is open to experiencing shame.

As Thom (1997b) purports, the drinking mother has been portrayed as something which is nationally harmful and in need of control, with the consumption of alcohol and motherhood often perceived as incompatible. A strong correlation exists between women's alcohol consumption and the notion of a 'bad mother' as the drunken woman is perceived to be 'out of control', and consequently is not viewed as a responsible mother who should place the needs of her child before her own. This highlights the notion that women's bodies are more in need of control and surveillance than those of their male counterparts (Ettorre, 2007) especially when pregnant as the rights of the mother are called into question (Thom, 1997b, Oaks, 2000, Jones and Chandler, 2007).

High levels of alcohol consumption are considered a problem requiring intervention (Bell et al., 2011) and, due to the gender differentiation, this is especially true for women. The introduction of a recommendation for abstinence from alcohol during pregnancy has led to the portrayal of women who drink even a small amount of alcohol during pregnancy as threatening creatures (Lupton, 1999b, Humphries, 1999), leaving them at risk of being stigmatised and consequently losing their respectability (Ettorre and Kingdon, 2010, Hunting and Browne, 2012).

## **7.2. GENDER AND THE FEMINISATION OF WINE**

Drinking is still a gendered activity within the UK (Holloway et al. (2009), however the rates for women's alcohol consumption are increasing. Ricciardelli et al. (2001) suggests that the reporting of alcohol use by women has increased due to the relaxation of gender roles and increased women's social emancipation. Public drinking spaces are increasingly been designed to attract women drinkers (Holloway et al., 2009) and the pub is now less of a male dominated space with women being generally more accepted in this environment (Pratten and Carlier, 2012, Holloway et al., 2009, Leyshon, 2008). Yet a double standard is still applied to women's alcohol consumption. Although less likely to drink than men, they are more likely to face opposition for their alcohol consumption (Campbell, 2000a, Waterson, 2000b, Ettorre, 1997).

It is generally accepted that women and men's drinking patterns show differences as they consume different beverages, with women who consume stereotypical male drinks such as pints of beer, becoming masculinised, labelled as 'larger louts', thus demonstrating a predominant idea that 'masculinity can be established through a bottle' (Ettorre, 1997, p.15). Some of the mothers in this study touched upon these gender differences in the type of alcohol consumed:

My dad and my uncle having a few beers or maybe a glass of wine, my mum is not a big drinker at all she doesn't drink anything unless it's got lemonade in it

Jennifer, 20, Edinburgh

Even now I don't drink any spirits, I don't drink beer, I do like wine and I do like champagne

Leah, 39, Inverness

This gender difference emerged most predominantly through wine, which was by far the most popular drink for the women within the study, resulting in wine being mentioned 164 times across 21 interviews, with all women mentioning it at some point in their narrative. The presence of the word alcohol within the narratives of the women helped to highlight the role of alcohol in the construction of identity and the role of the feminization of wine (Otto, 1980). Wine is gendered as it is a popular drink for women; data from the USA suggested that 80% of wine bought was purchased by women (Atkin and Nowak, 2007).

Drinking alcohol is part of the expression of identity in many societies and, as Wilson (2005) argues, it is an element of national cultures. Alcohol played a role in the women's pre-pregnancy identity, where drinking was for most women an unproblematic behaviour, which helped to fuse social identities with friends, and the consumption of wine in particular was common. The women in this study used alcohol as a social lubricant (Heath, 1999) and this was especially true in the consumption of wine, where women would share a bottle with friends or with their partner. In their descriptions of this, wine was seen as a feminine drink, which for nearly all the women interviewed formed a part of their pre-pregnancy identity and was frequently consumed with friends or 'the girls':

I had a glass of wine one evening with friends

Elsie, 42, Edinburgh

Similarly Florence also referred to consuming wine with friends as a social activity:

If I'm having a bottle of wine with my friend, they will all seem quite tidily

Florence, 31, Edinburgh

Wine was evidently a strong part of women's pre-pregnancy identity for nearly all of the women in this study. Most of the participants within the study described drinking wine with their partner at home as a usual pastime before they had become pregnant. This is unsurprising given that data reveal that the supermarket is now the most common space in which women buy alcohol (Ladder and Goddrad, 2007, Holloway et al., 2009), and the rise in popularity of the home as a drinking space, which has largely been seen as non-problematic (Foster, 2012, Foster et al., 2010).

If we're staying in, we will just have a bottle of wine here with food

Wendy, 33, Edinburgh

Similarly Mya recalled that her alcohol consumption prior to pregnancy often focussed around drinking in the home before she was pregnant often with friends or family:

We'll sit and have a wee glass of wine together and watch a DVD or things like that

Mya, 21, Edinburgh

Drinking wine was an important part of their social lives before becoming pregnant and therefore this habit was impacted upon once they were pregnant and they had to make choices around their level of alcohol consumption. Yet the health burden of home drinking is being increasingly recognised (Home Office, 2007). In Scotland, alcohol policies of minimum pricing and restricting discount offers now attempt to reduce the impact of home drinking (Foster, 2012). Wine was evidently part of the women's expression of identity pre-pregnancy. The work of Miller (2005) and

Phoenix et al. (1991) has recognised how becoming a mother changed the notion of identity and it is to be expected that a change would follow with alcohol consumption with recommendations to abstain and pressure to conform to a 'good' mother which is not associated with alcohol. Wine was used as a social lubricant by all the women prior to and after their pregnancies. It was used as a mechanism for bonding and also to remove tension. Mya described how she took her mum out and made sure that she had given her a glass of wine before plucking up the courage to tell her of her unplanned pregnancy.

I made sure that she'd had a few wines in her first

Mya, 21, Edinburgh

Wine was by far the most common drink described by the women in the study, both in their narrative about their alcohol consumption from pre-pregnancy, their current alcohol consumption levels at the time of interview and also from when they were pregnant. The consumption of wine in this way was reciprocal and it is evident that wine is also commonly used for the purpose of gift giving. For example, Florence, bought a card and a bottle of wine to thank a midwife who had helped her with her breastfeeding:

I ended up buying her a bottle of wine and a card and everything

Florence, 31, Edinburgh

### **7.3. THE CLASS-BASED NATURE OF ALCOHOL AND DRINKS WHICH WERE ACCEPTABLE TO CONSUME DURING PREGNANCY VERSUS THE DRINKS WHICH A 'GOOD' MOTHER SHOULD AVOID**

The consumption of different types of alcohol is class based in nature. As Nielsen et al. (2004) found in the study of socio-economic status on the relationship between type of alcohol and mortality, consumers of wine were wealthier and better educated in comparison to those who drank beer and spirits. Within Scotland, alcohol can be a (sub)cultural marker, as Young (2012) argues a preference for drinking the fortified wine 'Buckfast' is linked with the social grouping of a 'Ned' (non-educated delinquent, or 'Chav' in English). A finding within this study was that the classed nature of alcohol was an important feature in the choice to consume alcohol and the

discussion of pleasure gained from consuming it. As Waterson (2000b) argues the choice of alcohol type strongly indicates the social grouping of a person, and it was evident that certain types of alcohol also had perceived social connotations. As Wendy eluded, there were ‘sorts’ of drinks you consume on special occasions, when you want to celebrate. The classed nature of certain drinks was also hinted at by Wendy, who in meeting her friends for a celebratory afternoon after she had become a mother, she recalled sharing:

Baked camembert and bottles of Cava or Prosecco fizzy wine

Wendy, 33, Edinburgh

Wine was clearly perceived by the women in this study to be a higher classed drink, which links with the findings of Pettigrew (2002). This evidently influenced their choice to consume it over other types of alcohol. As the findings of Catalyst Health Economics Consultants LTD (2001) conclude alcohol consumption differs by social class in Scotland. Linked to this was the way in which participants noted the increased cultural capital associated with the appreciation of fine wine:

So now you know we kind of enjoy nice wines, and don’t want to drink any of the rubbish

Tina, 32, Edinburgh

A clear dichotomy emerged between what was perceived to be a ‘good’ type of alcohol versus a ‘bad’ type; this was especially prominent for the women in their discussions surrounding the type of alcohol they consumed during pregnancy. Drinks that were of a higher class in their nature, such as wine and champagne, were sanctioned as acceptable to be consumed, and were the most common drinks to have been reportedly consumed by the women in this study during pregnancy. Across the women’s narratives, the discourse that women should avoid consuming certain types of alcohol during pregnancy that were perceived to be ‘stronger’ in strength, such as spirits, or more lower class such as cider became apparent. The women’s choices around alcohol during pregnancy revealed a notion that if you were going to choose to drink during pregnancy that it would be reasonable to drink wine or champagne. These drinks, which appear more feminine and delicate, did not have a perceived connotation of harm. This categorisation of wine and champagne as a ‘good’ type of

alcohol, in comparison to spirits, which should be avoided, was demonstrated by Yvette in her narrative of what she drank during pregnancy:

It must have averaged out at like two glasses a month of wine or something, I didn't drink spirits at all. At Christmas I had sort of had a glass of champagne and a few sips of wine at Christmas dinner and that sort of thing

Yvette, 35-44, Edinburgh

The feminisation of wine and its connotation as an acceptable type of alcohol has an impact for health recommendations. The women in this study singled out spirits as particularly harmful and evidently perceived them as something that should be avoided during pregnancy. Although a standardised unit of any type of alcohol is the same, the discourses surrounding wine highlighted the lay consensus that a unit of wine is not perceived to be as harmful as a unit of vodka. This is important when considering what recommendations are given to women regarding alcohol, as the understanding of what a unit of alcohol is has often been problematic (Gill and Donaghy, 2004, Kerr and Stockwell, 2012). (For a further discussion of the problem of the unit see Section 7.6). This resonates with the findings by Waterson (2000b) who found in her study of women's drinking that not all alcoholic beverages were ranked equally. Catriona also highlighted this perception:

So particularly, like obviously everyone knows that you shouldn't get really drunk and drink loads of vodka, I think the advice for whether you are allowed one glass or two glasses of wine is very blurred

Catriona, 29, Edinburgh

Here Catriona highlights the common sense idea of the mothers within this study that a woman should not get drunk whilst pregnant, and this is apparently a fact that everyone should know; again the work of Geertz (1983) and 'common sense' is useful here (see Chapter 4). This notion can be linked again to the perceptions that alcohol is masculinised (Rúðólfssdóttir and Morgan, 2009, Ettorre, 1997) and that women, especially mothers should not get drunk (Thom, 1997b, Lyons and Willott, 2008). Revealing how women are still represented as the guardians of morals and drinking objectively evidences a decline in morals (Ettorre, 1992). Secondly,

Catriona also re-iterates the notion that the consumption of vodka is perceived to be potentially more harmful to the foetus than the consumption of wine. This is subtly emphasised by Catriona as she describes wine as being a substance which women are “allowed” to drink. The use of the word “allowed” is fascinating, as on one level it can be inferred that there is some idea of entitlement to alcohol that you are allowed to consume a certain amount of it. However this word also has strong connotations with the themes of surveillance and power relationships that are present over women’s consumption of alcohol in general and also the discourses that surround alcohol consumption in pregnancy, indicating that women have permission to decide how much alcohol they are allowed to consume. Drinking during pregnancy is not a criminal act currently within the UK. However in some states in America drinking during pregnancy is punishable (Campbell and Ettorre, 2011, Handwerker, 1994, Rothman, 2000, Connolly-Ahern and Broadway, 2008, Daniels, 1993). Although it is not punishable in the UK, some of the participants were still aware of the strong social sanctions that exist around it.

Again Catriona touches upon the theme of othering, hinting that it is an ‘other’ type of women who would drink vodka during pregnancy. She contrasts herself to this woman by the negative idea that this ‘other’ woman is perhaps uneducated to the risks that drinking during pregnancy might pose and therefore not a ‘good’ mother. This has strong associations with othering, which is common across women’s alcohol consumption. Catriona therefore defines her alcohol consumption in strong opposition to these ‘other’ women to resist her becoming stigmatised for her own alcohol consumption. She is therefore aware that alcohol consumption in general is becoming stigmatised but protects herself by ensuring she is not stigmatised like the ‘other’ drinking vodka. This is in line with Rolfe et al. (2009, p.332) who argue ‘women need to protect themselves against the image of the publicly drunken, unruly woman. This is achieved primarily through a process of othering, in which women are able to project the unacceptable face of women’s drinking onto other (frequently younger) women, leaving their own identities unspoiled’. This was clearly a class based assumption, linked to the ways in which alcohol was perceived as being classed.

The women’s accounts across this study revealed a perception that a small amount of wine during pregnancy is a culturally acceptable behaviour, and is normalised for

women who want to consume a low level of alcohol during pregnancy, but that the consumption of certain types of alcohol such as spirits should be avoided altogether. This was perhaps because of the perceived strength of spirits, but also perhaps because of the negative associations with spirits as drinks associated with problematic drinking. Spirits also often appeared within the women's narratives in often 'negative' experiences which women had with alcohol as teenagers or students or from their parents problematic drinking or alcohol misuse.

The discourses surrounding wine emphasised wine to be an acceptable drink for women; it is feminine and perceived by many to be a women's drink, in comparison to other types of alcohol such as beer and spirits which are more masculine types of alcohol. Because of its classed and feminine nature, drinking wine was shown to have strong links with the identity of women, and crucially was not harmful to the ideal of a 'good' mother. We must be mindful therefore that wine needs to be considered as part of wider lifestyle choices (Holloway et al., 2008).

#### **7.4. WINE AS AN ACCOMPANIMENT TO FOOD**

Linked to the acceptability of the consumption of wine during pregnancy was the way in which wine was described as an accompaniment to food, this is similar to the findings of Foster et al. (2010) who found people drink at home with food. In this respect wine lost its identity as a drug or something which should be avoided and was seen more as an addition to the meal setting which was commonly utilised.

Women within the study prominently spoke about consuming wine at mealtimes before they were pregnant:

I first met Gregory, we would have nice dinners and wines and things

Tina, 32, Edinburgh

We used to eat out quite a lot so we would drink wine and things

Rhea, 35, Edinburgh

As these quotes suggest, drinking wine at a meal setting prior to pregnancy was a normal behaviour for the women within the study, and it was something that the participants took pleasure in doing. Alcohol was therefore seen as a 'gastronomic



culinary pleasure' (Rolfe et al., 2009, p.330) and this was evident in the type of alcohol consumed, as wine was most highly associated with mealtimes. Parallels emerged between how women recounted the pleasure of alcohol similar to that in their discussions around food (Rolfe et al., 2009). The perception of wine as an accompaniment to food continued for some women into their pregnancy and they continued to consume alcohol with dinner. Drinking with food was therefore a common time women reported to choose to drink alcohol during pregnancy:

Just like a glass of wine with dinner or something like that... I think I just had a glass of wine with our meal

Catriona, 29, Edinburgh

Olivia also described how wine was often used as an accompaniment to food during pregnancy:

Erm nights out or a glass of wine with dinner and that is about it

Olivia, 32, Edinburgh

Alcohol in this sense is seen as an accompaniment to food, in the same manner as other condiments. Holloway et al. (2008) argue that there is a lack of research into private drinking environments and this is particularly significant for women, who are more likely to consume alcohol within a home or private environment. The findings build upon the work of Holloway et al. (2008) to reveal that the private drinking space is clearly important for women during pregnancy as it allows for a space away from the gaze of others and prevents women from feeling judged for their behaviour. In this way, drinking alcohol at home within a meal setting is a more classed thing to do and more luxurious than going out for a drink. (For a further discussion about the role of place in the consumption of alcohol during pregnancy see Chapter 6). Other women also reported that alcohol was most often consumed at mealtimes:

I had a glass of red wine with my dinner

Eilidh, 35, Inverness

Zoe also revealed that on occasions during pregnancy she also had wine with her dinner:

You know we had nice food and I like to have a glass of wine to go with it

Zoe, 42, Edinburgh

In this sense Zoe demonstrates that alcohol is an afterthought; confirming how Rolfe et al. (2009, p.330) describe the consumption of alcohol as a 'utility in relation to eating good food'. This finding is also in line with the findings of Pettigrew and Charters (2006) into the Australian perceptions of the relationships between food, which found that the consumption of wine is strongly related to food. Wine was perceived to be acceptable to have with food during pregnancy, not only within the home sphere but also when going out for dinner to a restaurant. As Paige expressed:

Five months pregnant I had the occasional glass of wine, erm maybe with a meal if we were going out

Paige, 28, Edinburgh

Tina also recalled times when she was pregnant when she consumed alcohol with food when out within a meal setting:

Very occasional odd glass of wine during my pregnancy and that was probably only like if we were out for a meal, or if someone was round for dinner, or if it was a particularly special occasion or whatever

Tina, 32, Edinburgh

From these women's accounts drinking alcohol as an accompaniment to a meal did not have any association with harm to the foetus. It was found instead to be a more socially acceptable time to drink during pregnancy. Across the narratives it therefore appears more reasonable if you have an alcoholic drink with dinner in other people's presence as this indicates sociability and inclusion and in no way was associated with being a 'bad' mother. I would argue there is a class based nature to this as it is more acceptable to consume alcohol when dining out. Florence recalled being encouraged to consume alcohol during a meal by family members, who even specially made her a spritzer to try and include her in the celebration of Christmas:

The Christmas when I was pregnant, I was at my in-laws and err, she, she poured me a spritzer with Christmas dinner like a white wine spritzer, erm you know so that I could have a drink

Florence, 31, Edinburgh

Copelton (2007) argues that eating is a significant social act that is charged with moral meaning and alcohol is seen as an accompaniment to food. I would argue that drinking alcohol, especially wine is seen as a significant social act, and a firm part of a woman's pre-pregnancy identity. Continuing to drink alcohol strong pregnancy may therefore be a continuation of this expression of identity.

This again highlights the celebratory nature of drinking alcohol. This act of watering down the alcohol to make a spritzer, also portrays a perception that watered down alcohol is safer; it was done so that Florence "could have a drink" and be socially included. The consumption of watered down alcohol therefore becomes socially acceptable, especially within a meal setting. It is evident from the above quotes that there is a perception that it is more acceptable to consume alcohol with a meal during pregnancy. Wine in particular was portrayed as an accompaniment to food rather than as a substance which should be avoided. Here the cultural acceptability of alcohol as an accompaniment to food is evident. This aligns with low-risk drinking guidelines in Canada which also outline that drinking whilst eating reduces the risks posed by alcohol consumption (Stockwell et al., 2012)

#### **7.5. FAMILIAL EXPERIENCE – THE INFLUENCE OF THE INTRODUCTION TO WINE IN CHILDHOOD**

In their narratives about alcohol consumption, the role of familial experience and their introduction to alcohol clearly impacted the women's attitudes towards alcohol consumption. Unsurprisingly, some women who had been through negative experiences around alcohol when they were children, such as having alcoholic parents or having had negative experiences around alcohol, had an affected view on alcohol. However, alcohol can have positive roles within families as recognised by Caan (2012). Jayne et al. (2012a) argue that the consumption of alcohol is a normal, taken for granted, part of family life and the way in which the women had been

introduced to alcohol typically influenced their attitudes towards it. Tina revealed that she had inherited the appreciation of fine wine from her father:

In my twenties until I started to drink and appreciate wine, nice wine, my dad is quite interested in wine he is a member of a wine club and learns lots of things about wine and that kind of thing, so he became that became kind of a hobby for him to be finding nice wines that went with food

Tina, 32, Edinburgh

Here Tina is talking about inherited cultural capital from her father. Cultural capital as defined by Bourdieu (1997) is used to explore social relations and educational inequalities, therefore the acquisition of capital sets one group apart from the next. Her choice of the word 'hobby' indicates that the consumption of wine for her is a harmless, leisurely past time, with strong positive associations with its enjoyment. This intellectual pursuit to learn about fine wine indicates the intergenerational transmission between father and daughter of drinking norms. It also serves to highlight the importance of the family and norms around alcohol use, in women's narratives around alcohol. Again the enjoyment of wine has classed connotations. Harm was therefore not associated with this behaviour, instead it is other women who drink vodka who cause harm.

Despite wine being more of a feminine drink; it is evident that it is socially acceptable for men to consume it when they have good extensive specialist knowledge of wines. The importance of drinking fine wine also gives more credence to the pleasure gained from the act of drinking. There is cultural capital associated with the knowledge and appreciation of fine wine (Holloway et al., 2008). The aspirational quality was also important as women wanted to learn about fine wine, often a habit inherited from their fathers. This intellectual pursuit is highly classed; however, as the price of wine has come down, making it more affordable, you don't have to have specialist knowledge of it to buy it any more. Instead fine wines can be enjoyed more generally.

It has been recognised how adult drinking patterns are influenced by childhood family cultures (Jayne et al., 2012a, Plant and Fossey, 1994, Valentine et al., 2012,

Waterson, 2000b) and it was clear that for some women in this study their consumption patterns were a learned behaviour. As Ferrins-Brown et al. (1999) found, the patterns of adult drinkers can be shaped by their early family experiences of alcohol and how they had been introduced to it by their family. Some of the women accounted their first experiences of alcohol being with their family, and being given alcohol by their parents, often within a meal setting:

My mum would let us have a glass of wine if we wanted in the house  
before we went out

Florence, 31, Edinburgh

For some women one of their earliest memories was consuming alcohol at meal-times with their family, and this was seen as a cultural thing to do, especially for Olivia who saw drinking wine with dinner as an Italian tradition.

Oh we had wine with dinner, my mum's Italian

Olivia, 32, Edinburgh

Drinking wine again with an evening meal was evidently a habit that some of these women had learnt from their family as it was part of their introduction to alcohol as children or teenagers.

An evening meal they wouldn't have drunk wine in the middle of the  
day for example

Catriona, 29, Edinburgh

How women were introduced to alcohol as children was predominantly through the tasting of wine as children, with family at the dinner table. Wine was therefore drunk in a social environment at mealtimes, not for the process to get drunk, but instead as a luxury to enjoy the taste of it. This coincides with Jayne et al. (2012a) who see the home as a safe place for children to be introduced to alcohol.

They would always have wine, and we'd have some mixed with  
lemonade

Catriona, 29, Edinburgh

Again the physical act of watering down wine makes it safer for children to consume it this was also true for pregnant women. The presence of alcohol within the narratives of the women helped to highlight the role of alcohol in the construction of identity. As Wilson (2005) argues, drinking alcohol is a key tradition in the expression of identity, and across this study alcohol played a role in the women's pre-pregnancy identity, where drinking was for most women an unproblematic behaviour, which helped to fuse social identities with friends. Elsie did describe this pattern also; however Elsie had previously had negative experiences with alcohol due to her father's alcoholism which she felt that she had inherited from him.

We would have a glass of wine two and that was you know we grew up doing...You know we used to have wine with meals...we would have it diluted, we would have a glass of wine say with you know if we had a special evening

Elsie, 42, Edinburgh

Elsie explained that she abstained completely during pregnancy because she recognised that she has a problematic relationship with alcohol. She purports an argument that consuming alcohol during pregnancy at a low level is acceptable, and that if she did not have this problematic relationship with alcohol she would have continued to consume alcohol during pregnancy.

I decided that I wouldn't because I couldn't just have a glass of wine, erm because as you would expect from my first experience of tasting alcohol, that is precisely what happened and I did end up having a problem with it, and I didn't trust myself to have the odd glass, so I abstained.

Elsie, 42, Edinburgh

Elsie relies upon her own self surveillance, knowing the possible harm that alcohol consumption could have. Her knowledge reveals awareness but also uncertainty over what it is acceptable to consume. However this recommendation is overseen because her relationship with alcohol is problematic. Her reasoning behind this discourse that it is acceptable to consume a glass of wine during pregnancy was based upon the old recommendation (see Section 1.2) given to women, and although Elsie shows an

awareness that the advice has changed she still demonstrates that she is unsure of what the new recommendation is. This may be because she felt through her own self-surveillance over her alcohol consumption that the advice was not applicable to her. She had made her own choice that it was best for her to abstain completely, as she would be unable to limit herself to drinking only one glass of wine.

#### **7.6. THE PROBLEMATIC NATURE OF USING THE UNIT AS A MEASUREMENT FOR ALCOHOL**

In their discussions around alcohol, only five women within the sample mentioned the term units. Most women in the study referred to the amount of alcohol they consumed in terms of glasses (and glasses of wine). Predominantly units were only mentioned in the women's recollections of conversations with their doctor, at the time when they had made a recommendation to them of how much alcohol they could consume during pregnancy. Yvette's description of her conversation with her GP over her level of alcohol consumption whilst she was trying to conceive highlighted this:

(Doctor) "Oh you shouldn't be drinking more than a couple of units, oh how many units?" err I said at the time "probably between seventeen and fourteen a week depending on what we're doing"

Yvette, 35-44, Edinburgh

Leah was also asked her level of consumption in units also at her doctor's and showed an awareness of the unit as a measurement:

I got asked to put down my units of alcohol in the doctors and I would say at the very most I would have and this is the very most, two glasses of wine in a week

Leah, 39, Inverness

Despite being asked about units, Leah responds in terms of glasses. These highlighted the ongoing problematic nature of a 'unit' as a measurement for alcohol (Kerr and Stockwell, 2012). Some women noted how the use of a unit as a measurement within recommended guidelines for women's alcohol during pregnancy may be problematic because not all women have a clear understanding of

what a unit of alcohol looks like, especially across different types of alcohol. Rhea's narrative also highlights this, as she makes reference to the way in which especially when drinking in private environments, such as the home, women often do not accurately measure their drinks.

I think there were concerns about women knowing what one or two units was and women drinking too much because they thought that it was okay to be having a glass of wine and what they would be having was one of those glasses that you would get in, you know one of them that's a third of a bottle of wine and probably about four units

Rhea, 35, Edinburgh

Through the use of different size glasses, women are often unable to accurately measure their consumption. Jennifer also demonstrated an awareness of how many units she could consume a week but she did not go into detail to show whether she accurately understood what a unit of alcohol is. Instead she made it apparent that she was recommended a maximum number of units per week for consumption during pregnancy:

Just telling me how many units I'm allowed to drink if I choose, if I wanted to do that

Jennifer, 20, Edinburgh

The use of units as a measurement tool therefore seems somewhat problematic for recommendations around alcohol as it is not clear if enough women fully understand it as a measurement. Researchers examining FAS have also highlighted the problems of using different measurements when trying to gauge alcohol consumption, for example Knupfer (1991, p.1067) argues that the number of drinks should be the unit of analysis as they are 'closer to the real world and easier to understand' and Abel (1998b) argues that it is problematic to compare 'drinks' as a 'drink' is not a standardised amount of alcohol. As already argued alcohol was judged by some women purely on its perceived strength, for example viewing spirits as 'stronger' than wine and not taking into account that a unit of wine is the same amount of alcohol and therefore may pose the same level of harm to an unborn child as a unit of wine. This is an interesting discussion as the idea of units has always caused



misunderstanding (Jayne et al., 2012b, Thom, 1999, Jayne et al., 2008) and also because recommended units change between men and women and between countries. It is very hard sometimes for women and men to understand how units may change, even within certain drinks such as wine, depending on the alcohol proof.

### **7.7. WHAT DRINKING MEANS? LAY HEALTH BELIEFS AS TO WHAT COUNTS AS A DRINK**

An interesting association with the problem of the unit was also the lay idea of what counts as a drink. Some women in this study reported abstaining from alcohol, but then went on to mention times they had drunk. This could be to prevent stigma but also highlighted the inconsistencies of what drinking alcohol means between women and what counts as a drink. Olivia was keen to identify that although she had consumed some alcohol during her pregnancy she did not ‘drink’ throughout her pregnancy. Others revealed that the times they had drunk during pregnancy were one off occasions. Wendy demonstrated this:

While I was pregnant I think I probably had about three glasses of wine the whole time, I had one at the wedding, one at my sister in laws hen do, and then one at my brother’s wedding cause he also got married while I was pregnant, and that was it. I didn’t even bother a mouthful here and there, I usually just drove

Wendy, 33, Edinburgh

Although Wendy refers to times when she has consumed alcohol, highlighting occasions where it is perceived to be acceptable for pregnant woman to have a celebratory drink, she ensures that it is clear that she maintained a low level of alcohol consumption throughout her pregnancy emphasising that she only consumed alcohol on a handful of occasions. This indicates an awareness of a discourse that you should abstain and that she was wary of the risk in that she could be judged or stigmatised. To be described as a ‘bad’ mother or to be deemed irresponsible seemed potentially worse by some of the participants than the risks associated with low levels of drinking. This is highlighted in the way she stressed that usually she “didn’t even bother” having a mouthful of alcohol, and is indicative of ensuring she is still

viewed in a good light as a woman who wishes not be judged negatively for her behaviour. This hints that the pleasure gained from consuming alcohol for some women was not the same unless you can enjoy it and have a few glasses of wine, Leah also implied this:

And I had attended a wedding I think during my second pregnancy, and I had had a glass of wine and that was it during the whole of the pregnancy, so essentially I didn't drink at all in either

Leah, 39, Inverness

Driving was synonymous with being pregnant and became a defence mechanism women developed to prevent them from being identified as abstaining from alcohol. For Leah, it is evident that she doesn't count her one glass of alcohol during pregnancy as meaning she drank during pregnancy, and she is keen to not be identified as someone who drank alcohol through her pregnancy. This was apparent as she exclaimed; "Essentially I didn't drink at all". This phrase gives an insight into the way in which women define what drinking is. Does drinking mean having one drink or does it mean for example being drunk? This is also important for how women's alcohol consumption during pregnancy is measured. Leah implies that, one drink doesn't matter, implying that it doesn't count. This is insightful as we try to gather accurate data from women on their alcohol consumption, something which we are already aware is under-reported (Holloway et al., 2008, Boniface and Shelton, 2013, Graham et al., 2010, Marchetta et al., 2012). It is important therefore that what drinking means to women is fully understood. Tina was keen to underplay the amount of alcohol that she consumed during pregnancy making reference to her very 'occasional' drinking and that she only had an 'odd glass'.

In terms of alcohol and things I would say I was probably about five or six months pregnant when I started to have the very occasional odd glass of wine during my pregnancy and that was probably only like if we were out for a meal, or if someone was round for dinner, or if it was a particularly special occasion or whatever

Tina, 32, Edinburgh

It was apparent therefore that women were aware of the discourses surrounding women's alcohol during pregnancy in that they risk being labelled as irresponsible mothers for reporting consuming too much alcohol. Alcohol was commonly consumed during pregnancy at 'special occasions', the above quote from Tina highlights again the differing localities where it was perceived by the women in this study to be acceptable to drink during pregnancy, in comparison to places where drinking should be avoided (for a further discussion of this see Chapter 6).

### **7.8. MESSAGES GIVEN TO WOMEN IN TERMS OF 'WINE'**

I have already demonstrated how some women in this study did not think the message of abstinence was meant for them because they are light drinkers as they 'other' themselves to the recommendation, therefore feeling it is explicitly aimed at 'other' women who do drink 'harder' substances who are seen in a negative light. As Pratten and Carlier (2012) argue wine is now a common product. The majority of women within the study were aware that the new recommendation is to avoid alcohol consumption during pregnancy, however very few women actually expressed an awareness of the reasoning behind this, other than a general attentiveness of the fact that drinking a large amount of alcohol could be harmful to the foetus. Only one woman specifically spoke about FAS; this was through knowing a couple who attended the same church who had adopted a girl who had been diagnosed with the disorder. Paige recognised that the potential for negative harm to the child was only linked to very heavy alcohol consumption during pregnancy, and she reflected on her own experience at working within the homeless sector where she had come into contact with women who had used drugs or alcohol during their pregnancies and had then gone on to have a healthy baby. Her perceptions of the direct cause of harm to the foetus from alcohol were therefore heavily influenced by these experiences and she recognised that from her experiences drinking to a very small level was therefore likely to be unproblematic.

I saw mums who had been on, really heavy methadone scripts when they were pregnant and things, and were drug users while they were pregnant while their babies were born, so that kind of puts it into

perspective in a way, so that the odd glass of wine isn't really going to make that much of a difference

Paige, 28, Edinburgh

Wine was therefore seen as a very unproblematic drink, especially when consumed at low levels, especially when in comparison to much harder substances and drugs. Women's definitions of alcohol-related harm were more general harms than specific detail and although Paige was aware of FAS, her perceptions of the harm that alcohol could bring were mediated through these other experiences. The lack of women actually speaking about the specific harms that high levels of alcohol could cause during pregnancy perhaps highlights a failing of the new recommendation for abstinence, in that women do not fully understand the risks that drinking alcohol during pregnancy can cause. However this could also be indicative of the fact that these women did not perceive these messages for abstinence to be aimed at them; instead they were aimed at 'other' women who consumed heavy amounts of alcohol. The women in this study therefore were aware that they probably shouldn't drink excessively but didn't allude to any reason why other than these generalised discourses of potential harm. As previously examined they did not feel the recommendation for abstinence was backed up by scientific evidence (see Section 4.3.2)

As previously argued, discourses around wine were important in the women's discussions of what level of alcohol they were able to consume during pregnancy. Nearly every women spoke about how recommendations that were made to them about alcohol during pregnancy were given to them in terms of wine. These messages explained how many glasses of wine they could consume, rather than how many units. As these participants explained:

Whether you are allowed one glass or two glasses of wine is very blurred

Catriona, 29, Edinburgh

Elsie also added:

It was okay to have the odd glass of wine, and I think that's what the advice used to be

Elsie, 42, Edinburgh

One or two glasses of wine or the 'odd' occasional glass were not seen as problematic. Similarly, these participants talked about amount of alcohol in terms of wine:

Erm so yeah especially wine, you know you sit and have one glass you're allowed to have that, and that's fine

Kylah, 25, Inverness

Similarly Florence linked messages around alcohol during pregnancy to drinking and driving, indicating:

That you can have a couple of glasses of wine and drive, but I never have

Florence, 31, Edinburgh

In her view you could therefore drink during pregnancy. When women spoke of recommendations made to them that a small amount of alcohol could be consumed during pregnancy (as per the old recommendation prior to 2007) these nearly always featured wine. Rachael's recollection of her advice from her doctor was that a low level of consumption of wine was unproblematic, he told her:

It doesn't actually harm the baby if you have a glass of wine with your meal, or erm if you have you know, the odd glass of wine here or there you know it's not going to make any difference

Rachael, 32, Inverness

This clearly reflects how messages were given to women in terms of wine, therefore highlights how wine is a feminised drink and how it is part of a woman's identity. Again this reveals how women see wine as a higher class drink (Pettigrew, 2002) as agreed by Holloway et al. (2008). The consumption of wine specifically may also

reflect how the affordability of wine has increased, as the price of wine has fallen compared to average earnings (Jayne et al., 2012a, Mintel, 2005). However due to the feminisation of wine and the problematic use of the unit, discussions around alcohol and pregnancy mainly feature around the acceptability of wine as a drink, which is classed and socially accepted even during pregnancy, especially as it has strong links as an accompaniment with food.

## **7.9. CONCLUSION**

It was evident that messages were often received in terms of wine, and wine was the most common drink consumed, a consideration needs to be made of whether we need to be more specific about wine or if recommendations or interventions should include references to wine. It appears that in discussing alcohol during pregnancy from the narratives of these women that there is still no firm understanding of what a unit as a measurement of alcohol represents.

The narratives highlighted a widely held belief of what types of alcohol are okay to be consumed during pregnancy; if a woman chooses to consume alcohol, wine or champagne appeared to be culturally sanctioned and had no perceived connotation with harm. This social/cultural context is important for women in the choices that they make. Champagne is fluffy, soft and glamorous and, with no indication of harm. This coincides with Lyons et al. (2006) who, in their examination of how alcohol is portrayed in the media, found that there were differences in the types of drinks women drank and enjoyed, especially in comparison to men. Drinks are therefore still gendered as wine is feminised. Women's drinks are more likely to be glamorous and sparkling, such as wine and champagne, and these drinks seem to be the drinks of choice for women whilst pregnant.

## **Chapter 8. Discussion**

### **8.1. INTRODUCTION**

This thesis is a feminist and life-course piece of research examining the consumption of alcohol during pregnancy, especially women's attitudes to alcohol, their awareness of the purported risks around drinking during pregnancy and the changes the impact of the introduction of the recommendation for abstinence by the Scottish Government in 2007. Utilising a feminist stance this research recommends that we gives power back to women, through the recognition of the male-dominated medical profession and the medicalization of motherhood and its impacts upon women. A large range of studies which look at women's alcohol consumption during pregnancy deal specifically with FAS, and fail to examine the reasons why women may continue to drink during pregnancy, or how the decision making process is informed. The use of a feminist methodology has endeavoured to negate power relations between the researcher and participants, and the methodology used for this research does this by giving the control of the interview topic to the participant. This research is original in that it examines the message of abstinence in Scotland through women's narratives to reveal the importance of personal and lay knowledge and discusses 'good' motherhood in women's decision making process regarding alcohol consumption during pregnancy. Its findings add to our understanding of the use of alcohol during pregnancy in Scotland and I would argue that the findings and theoretical implications are also relevant more widely.

Attitudes towards women's alcohol consumption during pregnancy and FAS in Canada and America indicate that there are strong efforts which seek to control women and prevent them from drinking alcohol during pregnancy. However this is not a simple matter, as it deals with aspects around choice and women's autonomy. There is ambiguity about the collection of symptoms of FAS as some of these overlap with other conditions and the impacts of drinking during pregnancy are contested by some authors (Ettorre, 1997, Armstrong and Abel, 2000, Barker and Hunt, 2004, Leppo and Hecksher, 2011, Lowe et al., 2010). This makes it a highly interesting topic to study, but the contestation makes this a more difficult subject to study, given that the diagnosis of FAS or the level of harm from drinking during pregnancy is not as clear cut or as simple as perhaps other illnesses for which there

are established diagnoses. This has implications for recommendations given to women and the credence given to autonomy in health behaviour.

These findings described in this thesis serve to highlight the importance of women's experience, and the necessity of talking to women, to understand further what influences their decision-making around their consumption of alcohol during pregnancy. It is apparent that many women feel that the push for abstinence in 2007 (The Department of Health, 2007) was made without consultation with women and without grounding or scientific justification. As the findings indicate this inevitably led women to question it.

## **8.2. HOW DO WOMEN RESPOND TO THE MESSAGES? THE IMPORTANCE OF LAY HEALTH BEHAVIOURS, THE DEVALUATION OF LAY KNOWLEDGE AND BEING A 'GOOD' MOTHER**

The findings highlighted the complexities of behaviour during pregnancy, especially around alcohol consumption, where choices were linked to past and current drinking patterns, self-expression of identity and ideas of motherhood. These complexities reveal how women's choices are influenced by discourses around motherhood and the importance of their understandings of being a 'good' mother. Expectations of alcohol consumption are therefore instilled with expectations of motherhood (Burton-Jeangros, 2011). The narratives of the participants served to highlight how motherhood is a biographical disruption and also how pregnancy is not the easy natural state which many presume it to be. At times, women revealed how they felt constrained by the changes they experienced and this affected their decisions around alcohol consumption.

The change in the recommendation to abstinence highlights the increased interest of the state in the well-being of the foetus, and that as these concerns are overly moral and not necessarily medical. I argue that the precautionary principle in pregnancy advice seems to fit well into the responsabilization agenda of neoliberal health policy (Ayo, 2011, Petersen, 2003, Salmon, 2010), yet I argue there are implications of this for women's rights to bodily autonomy and for women's identities within the framework of 'good' mothering. The women in this study do not drink alcohol during pregnancy due to maternal ignorance. Instead their decisions were made drawing on a range of discourses about what it pertains to be a 'good' mother and the



importance of responsibility. Health promotion campaigns may therefore assume that the solution is the education of women to the potential ‘risks’ of drinking during pregnancy; however as in the case of the UK, women are advised to abstain from pregnancy on an unidentifiable risk. Emphasising that women should modify their behaviour to avoid unknown risks fails to recognise the pleasure that many women receive from drinking. This expands research on pleasure to underline its importance in healthcare decisions, even during pregnancy. This is particularly relevant when considering the gendered and classed nature of alcohol especially when women are drinking wine, a drink which is increasingly associated with femininity and upper class etiquette and not the perceived idea of the harmful lower class mother putting her children at risk through the excessive consumption of alcohol. This draws on what Patterson (2004) defines as ‘validation stories’ as women reveal fears about being characterised as the wrong sort of person as they define who they are versus who they do not want to be. Mothering is highly contextualised (Vincent et al., 2010) and experiences of women are likely to vary between pregnancies (Griffiths et al., 2008), and especially as health interventions and recommendations change, as well as a change in public attitudes towards health behaviours.

There has been a subtext that if women are aware of the dangers of drinking alcohol during pregnancy that they will therefore avoid it. Mothers are therefore assumed to be ‘selfless’ in their decision-making process (Daniels, 1993). However, the findings revealed how knowledge does not always influence behaviour. Drinking during pregnancy is constructed as a public health and social problem, yet the recommendation for abstinence is not supported by scientific evidence, as the research indicates light drinking during pregnancy is unproblematic (Kelly et al., 2009, Kelly et al., 2010, Knupfer, 1991). As Plant (1986, p.84) argues: ‘available evidence, however, does not support the view that the overwhelming majority of pregnant women who are not excessive drinkers need feel alarmed or guilty’. The switch to a recommendation for abstinence therefore highlights increasing control over women and their behaviours, and that notions of motherhood still reflect the mother as the guarantor of society (Lawler, 2000). If women do not comply with the abstinence they risk being portrayed as self-indulgent and ‘bad’ mothers. Again the emphasis is on behaviour in pregnancy; pregnancy is no longer viewed as a natural state. Instead I argue is increasingly medicalised and instilled with the moral

expectations that are placed on motherhood, whilst simultaneously it serves to give the foetus agency and limit the women's autonomy. This reveals how moral discourses around drinking are still gendered (Day et al., 2004). As there is no association with harm from low levels of alcohol consumption during pregnancy, and in line with critical thinking, it needs to be considered why a low level of drinking alcohol during pregnancy is a problem for anyone other than the mother. For some women, drinking alcohol was clearly not a big deal. This revealed the importance of consideration of the context of the way alcohol is positioned in these women's lives. Some of the participants recognised the pleasures and benefits they gained through their consumption of alcohol since before pregnancy it was part of their pre-pregnancy identity. Some women therefore demonstrated a clear desire to consume a small amount of alcohol during pregnancy to retain these positive effects such as the pleasure gained from relaxation and sociability. Women did not choose to consume alcohol during pregnancy to put their child at risk. Instead they recognised the problematic nature of the message for abstinence, questioned it and utilised their own lay knowledge and that of their family and friends.

The findings of this study indicated the importance of lay knowledge in their decision-making around maternal alcohol consumption during pregnancy. As agreed by Blaxter (1997); Davidson et al. (2008) and Watkins et al. (2002) lay knowledge, has been devalued with increasing credence and authority given to medical knowledge which is often gendered (Coles et al., 2010). Henderson (2010) argues that it is expected that unhealthy behaviour is associated with knowledge deficit. However the participants within this study revealed an awareness of the purported risks of consuming alcohol, but chose to consume alcohol anyway. Although only one woman directly mentioned FAS as an outcome of heavy drinking, there was a general assumption that the heavy consumption of alcohol was something that should be avoided because of the potential harm it may bring. The importance of lay health beliefs influenced the women in this study in their choices to drink or to abstain. Since patients have access to a wide range of information they no longer rely exclusively on expert information. Instead, Henderson (2010) recognises that currently there is a great individual expectation for information, and the participants revealed in this study their desire to be informed and their behaviour at times was clearly information seeking. This adhered to the notion of a 'good' mother who does

the best for her child. It is a normal part of life to engage in activities that are not risk free, Leppo and Hecksher (2011) argue therefore, that in order to be credible, information needs to avoid exaggeration of risks. The women in this study understood the risk in relation to alcohol consumption during pregnancy. It is important therefore to question how commonplace the adoption of the total abstinence model is (Leppo and Hecksher, 2011).

It is naive to think that women are not aware that there is a risk to drinking alcohol during pregnancy, there may be the odd person who is unaware and for whom the specific risks are unknown and difficult to quantify. However, nearly all of the women in this study showed an awareness that drinking a large amount of alcohol during pregnancy is clearly not beneficial for pregnancy. Consequently, it is important that women are not treated as unintelligent. Presuming women are ignorant if they choose to drink alcohol during pregnancy reduces their autonomy. The findings revealed how women made a choice which was individualised and tailored towards them and was influenced by their lay health beliefs and experiences, which in turn was influenced by their drinking culture, previous and familial drinking patterns and history and experiences. I would therefore argue that women do not need to be 'educated' about the risks of alcohol; instead they should be supported in other ways. For the women in this study drinking is an acceptable behaviour if it is controlled. As Rolfe et al. (2009) highlight, the perceived need for self-control requires a shift from patriarchal control to that of the individual.

Although some of the theories around motherhood discussed in this thesis are relatively old, I argue that they are still valuable, as narratives around the 'good and 'bad' mother play an important part in women's decision-making processes during pregnancy. I argue that this issue of alcohol consumption during pregnancy is linked to the way in which moral judgements are made of women, for example the social problem of unplanned pregnancy, and the social idea that single, perhaps young women, have a child because they want a council house (Slack, 2009).

It is evident that this growing emphasis of the concern towards women drinking during pregnancy has come from the extension of the medicalisation of motherhood (Ettorre (1992), (Lupton, 1997a, Oakley, 1984, Rothman, 2000) and pregnancy and the perception that the maternal-foetal relationship is strained (Oaks, 2001, Casper,

1994). This issue has clearly escalated given to the increased publication around FAS, and the construction of the low consumption of alcohol as problematic, these representations are presented within the media in the UK. This serves to highlight the way in which different things are picked upon by the media and vilified, revealing a discourse of women as dangerous. This also has strong links to the way in which motherhood is valued and how popular constructions of the mother remain.

### **8.3. THE INFLUENCE OF CLASS**

The findings of this research highlight that there are issues around setting the recommendations for abstinence. One result of the move to abstinence has led to increasing portrayal of women who consume alcohol during pregnancy as ‘bad’ mothers. The concept of the foetus as a patient with rights (Fasouliotis and Schenker, 2000) and that the consumption of alcohol during pregnancy is a threat to the foetus affects how we perceive the rights of the mother as a moral agent. This is linked to the awareness of how women are subject to constant judgement, by the gaze of others, such as professionals who seek to legitimise and normalise certain types of behaviour and women’s ability of functioning as a ‘good’ mother. There is a presumption that individuals have access to a range of cultures as discourses of choice are central to the western production of ideas of individuality (Skeggs, 2005). Yet women seem to no longer have any choice over their consumption of alcohol during pregnancy, even given that there is currently no research which identifies low level of consumption as problematic. This research therefore highlights the need for delivering consistent health messages to women.

This thesis therefore makes an important contribution to the importance of class in women’s alcohol consumption during pregnancy. A behaviour which is stigmatised by some evidently has class-based origins in the way in which women choose their health behaviours. Class is thus influential in how the good citizen and, in turn, the ‘good’ mother is defined. Doing femininity, ‘the process through which women are gendered and become specific sorts of women’ (Skeggs, 2001, p.297) is therefore a form of cultural capital. It therefore means different things to women of different classes. As the emergence of femininity as an ideal, women of different classes are therefore not expected to inhabit femininity in the same way, for example the working class is perceived to be dysfunctional. Class issues symbolically position

women of lower class to have no value. The women in this study, by positioning themselves as women who only drank wine during pregnancy, what women professed to be a safer 'upper-class drink'; were therefore being 'good' mothers. The results of this study reveal that, through their alcohol consumption choices, women are defending their value and disassociating themselves from other women. This adds to the way in which appearance as a means by which women become categorised through moral evaluations, has become 'the signifier of conduct' (Skeggs, 2001, p.297). As Holdsworth and Robinson (2013, p.106) argue in their discussion of smoking and children's anxieties 'prevailing views on the undesirability of smoking not only castigates those who smoke but accentuates moral repulsion about their class background'. I would argue this is also true for women who drink and the perception of the type of woman who continues to drink alcohol whilst pregnant, revealing therefore how class is perceived. Drinking during pregnancy therefore demarcates not only a woman's class but also helps to reinforce moral judgements about her class. The discourse that working-class mothers binge drink during pregnancy and represent not only threats to themselves but also to the nation and more recently her unborn child, has left women who consume alcohol during pregnancy being stigmatised. Women are the markers of national moral values, the imperative is therefore to be an ethical self; failure to be responsible or have self-control therefore leads to identification as a 'social problem'. I argue that the change to abstinence has left women at risk of being identified and stigmatised in this way.

Class therefore effects how we judge others. As responsibility for health outcomes is increasingly transferred to the individual, moral judgements about behaviour are integral to how class is recognised. Yet the importance of being respectable (Skeggs, 1997) and the risk of being judged by members of other classes (Lawler, 2005) ensures that women aim to meet the demands of respectability, which include good mothering (Vincent et al., 2010).

The work of Skeggs (2009, p.629) is therefore highly relevant to this research in its examination of class and how 'certain bodies become inscribed with certain characteristics', for example, the ways in which types of behaviour are expected from certain types of people, I would argue that drinking during pregnancy is an example of this and that the process of becoming feminine is a class process. A

unique finding of this research is the way in which drinking during pregnancy is defined as a problem through the classed social construction of drinking aesthetics. The middle class context of drinking wine, such as sipping wine is acceptable during pregnancy and in no way associated with harm. There is an evident class issue arising as critiques about poorer households include the affordability of alcohol and moral panic over the effects of ‘uncontrollable’ women drinking during pregnancy have developed. There is a class issue regarding women’s alcohol consumption during pregnancy where middle class drinking doesn’t induce panic in the same way. This impacts the way in which mothers are valued and the role of class.

#### **8.4. THE FEMINISATION OF WINE**

The importance of pleasure in women’s decision making processes was also linked to the type of alcohol women drink. The interviewees revealed how the messages regarding alcohol during pregnancy were mostly given to them in terms of wine which made its consumption therefore seem unproblematic. The type of alcohol was also gendered, as most frequently wine and champagne were drunk in celebration, and provided feelings of pleasure and had no association with harm. An original finding of this research is the feminisation of wine. As has already been discussed, wine has a role in identification around class, but wine has also been established as a more feminine drink in comparison to more masculine drinks, the findings reveal that across the women’s narratives wine is perceived to be ‘safer’ than other forms of alcohol. It was therefore seen as non-problematic and portrayed as conventional, and is drunk at social occasions for social bonding and inclusion, at meals or as an accompaniment to food.

The findings of this research therefore revealed desirable drinks such as wine and champagne to be culturally acceptable drinks, due to the upper class connotations, as women did not associate them with harm. This work therefore builds upon existing work that examines how drinking is an expression of identity (Nielsen et al., 2004, Young, 2012, Waterson, 2000b, Pettigrew, 2002, Ettorre, 1997) revealing wine as a ‘safe’ drink, for women to choose to consume, even whilst pregnant. I argue therefore this is an important finding and it bears an influence on how alcohol is portrayed within the media and advertising campaigns, given the way women are now targeted as alcohol consumers. This develops writings around the notions of

pleasure and positive drinking. The autonomy of women is important given that women are open to a discussion of the role of pleasure at a time where women are open to stigmatisation for revealing their alcohol consumption.

### *Pleasure*

The findings revealed the often neglected importance of pleasure and the social nature of alcohol consumption in women's health decision making. The role of pleasure therefore needs to be understood as it is evident that some participants do not see the benefits of abstaining and do not trust the medical guidelines. This research deals with the larger debates around the normalization of alcohol within Scotland and the UK and how, because drinking alcohol has become such an accepted behaviour, to not drink is consequently seen as boring. This can in turn leave women who chose to abstain from alcohol during pregnancy feeling very isolated. As evidenced, drinking has become normalised within the UK and Scotland. The women within this study were clearly aware of how their drinking practices formed a part of their pre-pregnancy identity, revealing the importance of drinking to relax and socialise. These findings also revealed how many people now expect pregnant women to abstain during pregnancy and how abstinence is associated with pregnancy, yet they also revealed how, because of the normalisation of alcohol within the UK, to not drink alcohol is perceived as boring and sets the pregnant women as the 'odd one out.'

This research gives detailed examination towards discourses of harm and moral judgements linked to the consumption of alcohol during pregnancy by women. This research reveals the importance of an under-developed discourse of pleasure in women's decision-making process. It is not unsurprising that pleasure in this regard is neglected given the increased attention paid towards alcohol harm and concerns over motherhood for women who continue to consume alcohol to some degree during pregnancy. Because of the moralisation of this topic and the debates about FAS, there has been increasing attention given to the role of the foetus, and the idea that women may drink for pleasure does not seem compatible with this.

## **8.5. SELF SURVEILLANCE AND THE SURVEILLANCE OF WOMEN AND THE DISCOURSES OF POWER**

The discourse of individual responsibility is evident within Scotland as the responsibility is on pregnant women to be self-regulating, although women do not appear to be taking the messages on board. These experiences serve to highlight the way in which women in the UK self-regulate their alcohol consumption during pregnancy. The women in the study showed awareness that by identifying themselves as women who drank during pregnancy they risk being judged as irresponsible. Yet the adoption of the abstinence message highlights an attitude towards legislation within Britain that the population can't control themselves.

It is possible women's bodies are over surveyed as powerful groups use their knowledge to subjugate those with less power by positioning them as 'other' or 'bad' mothers. Special attention is directed at high-risk groups which positions them within a network of surveillance and monitoring (Lupton, 1999a). Pregnant women appear to be surveyed in practically every manner and it is possible that women are becoming selective in their decisions. Women often recalled drinking during pregnancy in the home. As drinking during pregnancy is a "behind closed doors" activity this highlighted the importance of public versus private drinking spheres. These findings develop further the importance of the turn to examine the impact of drinking in the home (Foster, 2012, Kneale and French, 2008, Measham, 2006) and drinking practices such as pre-loading (Barton and Husk, 2012, Degun, 2013). There has been a call for greater attention to be paid to drinking in the home, given the rise of off-sales of alcohol; this is clearly a sphere where women are more likely to consume alcohol during pregnancy. It also revealed how it is easier to regulate women's behaviour in public contexts as drinking during pregnancy remains socially regulated within the UK and Scotland. Despite this, some women reported receiving encouragement to drink by friends and family and this highlights again the importance of lay knowledge in women's decision making processes.

It is evident that within the UK there is a different cultural attitude to the consumption of alcohol than in America; this is also true for the consumption of alcohol during pregnancy. Measures to prevent the consumption of alcohol during pregnancy are seen as more punitive in America, and seek to control women's



behaviours. This piece of work engages with the theory of power as proposed by Foucault (1979) to help us further understand and engage with issues around women's alcohol consumption during pregnancy. I argue against using these preventative measures in Scotland, instead arguing that messages around drinking during pregnancy need to hand control and power over to women, supporting them further by putting the decision to drink in their hands, instead of attempting coercive measures aimed at controlling women's bodies. It is important therefore that women's autonomy is recognised when we examine the consumption of alcohol during pregnancy, and that we understand that women do not drink during pregnancy out of an ignorance or lack of knowledge of messages. This message concurs with that of Gavaghan (2009) by arguing that the message of abstinence is received by women as patronising. Drawing on theories of power as asserted by Foucault (1979), the study reveals how the interaction between technologies of power and of the self that progressively impress upon women the responsibility for their health (Holdsworth and Robinson, 2013, p.103) and in this case also the health of their unborn child. The findings revealed how women were aware of external sources of surveillance and disciplinary power (Lupton, 1997a) that exist as they abstained from alcohol or adjusted their consumption i.e. chose to drink in private space or in the home. As self-regulated citizens, women do minimise the risks to which they are exposed, but because messages given to them on alcohol during pregnancy are mixed and inconsistent, women revert to lay knowledge in their choice and question the authority who sets these messages.

The consumption of alcohol by women during pregnancy is frequently discussed but this research highlights under-researched themes, especially the aspect of pleasure and risk in women's decision making and consideration of drinking alcohol during pregnancy. This research builds upon theories of power as it reveals how women negate power by drawing upon class-based narratives of the 'good' mother. The references used for some of this research draw on older theories of power and motherhood, but I would argue that these are still extremely relevant issues which are the most appropriate for developing our understanding of this research.

It is interesting how we understand and examine power and its effect on women's decision making during around the consumption of alcohol during pregnancy, given the broad precaution of harm expelled by the abstinence message, which I would

argue is based on moral principles. The abstinence message of ‘do not drink’ is not appropriate therefore as it fails to engage with women’s autonomy, and the way in which women make health choices around notions of responsibility utilising the good’ mother ideology.

## **8.6. IMPLICATIONS OF THE RECOMMENDATION FOR ABSTINENCE**

These findings have revealed how the messages given to women about their alcohol consumption during pregnancy become internalised and acted upon. I have argued that since the recommendation for abstinence was introduced, an increased awareness is now being paid to women’s alcohol consumption and more specifically the consumption of alcohol by women during pregnancy. This has led to what Cohen (2002) defines as a moral panic over women’s alcohol during pregnancy, and in turn an increased worry over the need to control women’s drinking. This has been fuelled in part, by the strong negative assumptions made between drinking during pregnancy and its association with the discourse of the ‘bad’ mother. Alcohol consumption is very high in Scotland, in comparison to both the rest of the UK and other countries, yet there appears to be a ‘backlash’ towards the change in guidance by women, and also by some commentators (Lowe and Lee, 2010, Leppo and Hecksher, 2011). It appears therefore that as there is uncertainty over the level of harm linked to the consumption of alcohol in pregnancy that this is an important area where policy could be better informed. This research has addressed this gap, by adding original findings alongside some recommendations for public policy and further research (see Section 9.3).

This research is highly relevant given the change to guidance to abstinence in Scotland but also is very timely. This piece of research is the first to examine this topic since the change of legislation in 2007. The study draws upon a large amount of theory and literature on a variety of topics to examine the topic more deeply. The range in literature has been assisted by the change, I as a researcher, have undergone since starting this research, moving between the departments of Human Geography, Health and Community Research and Sociology.

### *Lack of Consistency in Message*

It was still apparent that there is a lack of clarity on the messages given to women regarding women's alcohol consumption during pregnancy. This is in line with the fact that there is ambivalence towards the harm of alcohol consumption during pregnancy. The fluctuations in recommendations given to women again highlight this knowledge gap that exists, and reinforces that there is no conclusive evidence of harm at low to moderate levels of alcohol consumption. However this presents a challenge as how risks should be conveyed to women.

The findings of this research indicate that the guidance on alcohol during pregnancy is unclear and this is obviously unhelpful in assisting women making their choices. As already argued the inconsistencies led the women in this study to challenge the recommendation for abstinence. The challenge therefore remains about how a clear message that leaves no doubt can be made to women. It could be questioned if abstinence is the right message for this if it is not backed up by scientific evidence. As it leads women to question the guidance they are given, a behaviour that could then lead to trust issues with advice could also then be replicated with other advice.

Because there is a lack of concrete evidence behind the guideline it is therefore questioned by individuals but also possibly by health professionals too. It is not simply a case that women should be given this message, it needs to be explained more honestly and openly that we simply don't know if alcohol at low levels poses a risk to the health of the foetus. If the health professionals give the message but then do not back it up, then women may fail to understand or follow it. The way that messages are given or women are told is therefore influential. The findings in Chapter 4 indicated that not only does it matter what messages are given to women but also that messages are dependent upon the way they are given to women and the manner of how they are delivered. The inconsistency in message reveals that further examination needs to be given to the way in which messages are given to women. As these findings reveal, lay knowledge is especially important in women's decision making around the consumption of alcohol during pregnancy.

It needs to be ensured that women are no longer constructed as the problem to FAS or other negative effects of drinking alcohol during pregnancy but instead are viewed as the solution. This is also important so that women are not thought to be in need of

treatment, which would have the potential consequences of further stigmatisation for women. A universal message of support is therefore more appropriate than making women feel as if they are being punished or sanctioned for a behaviour which is not criminalised. The guidance is therefore still confused but if the abstinence message is not continued what else would be a clear message? Linked to the lack of consistency in the message was also the way in which women did not understand units and what a unit represents. The women in the study did seem to be aware of what a unit is, but revealed that is not a realisable unit of measurement for them. It also does not work in the home setting where people do tend not to measure their drinks. Is there another way which would be better to communicate messages? This is important as women in this study were talking about their alcohol consumption in terms of drinks and glasses of wine or champagne.

Policy that draws on stigma and by shaming women to avoid harming their child as seen in the US is possibly not the most beneficial way of breaking the pattern of drinking during pregnancy. It is evident that in some situations drinking in pregnancy has been evident for generations, passed down from the encouragement to drink Guinness and stout for its iron qualities, highlighting the importance of intergenerational knowledge. The way these women are positioned leaves them vulnerable to criticism. The abstinence message is therefore targeted at all women rather than those most at risk, there are implications of this for alcoholics, who drink during pregnancy, who tend to be viewed to have moral failings as women and mothers, rather than an addiction.

### ***How should we communicate risk to women?***

The individualistic assumption that is present in messages around women's alcohol consumption during pregnancy is that alcohol is used because of inadequate knowledge of the risks it may present to the foetus. However this study revealed that many of the women who participated, and who continued to consume alcohol to some degree during pregnancy, were aware of the risks or the recommendation for abstinence. Instead they made their choices around alcohol consumption based on lay discourses, around themes of pleasure, the normalisation of alcohol and the lack of belief or trust in the mixed messages which they were given. Women therefore need to be able to make informed decisions around their health. The use of the word

risk within medical literature and in trying to identify women who drink during pregnancy is problematic. It infers that there is a danger to the unborn child. This only serves to feed the idea that the maternal-foetal relationship is problematic (Lupton, 1999b, Lisa, 1994) and eludes that the health of the foetus is of higher importance than that of the women herself and brings into argument the rights of the foetus.

Attention needs to be paid on how we communicate risk to women, and whether a caution based principle such as argued for by Leppo and Hecksher (2011), is appropriate or should we use a risk estimate in the message. This leads to debates on the rationale and justification of public policy. The use of words such as ‘risks’, ‘management’ and ‘control’ by the medical profession only serves to objectify women, and makes them appear to be something that needs to be surveyed and controlled. The call to do pregnancy the right way is therefore linked to the increased individual management of risks and harm. Self-governance is utilised by women so as to protect their moral identities through demonstrating self-control over their alcohol consumption; this is part of the individualised project of self surveillance (Rolfe et al., 2009). Unfortunately, messages are not being backed up; for example women are supported to give up smoking and referred to a stop smoking service which is seen as important as it links to other medical intervention, such blood pressure measurements.

### ***Debates on the rationale and justification of public policy***

There is still debate over the best way to decrease inequalities and reduce alcohol harm in Scotland (Johnston et al., 2012). Public health messages are unclear and appear to be based on moral judgements, of which FAS is being framed as the latest medical response. The adoption of total abstinence messages, such as can be seen in Scotland, the USA, Finland, Denmark or Australia, with the strictest alcohol policy traditionally being found in the USA, has been accompanied by controversy, as this policy is based upon the principle of precaution rather than based upon research evidence suggesting that low or moderate levels of alcohol consumption during pregnancy causes harm (Leppo and Hecksher, 2011).

It is important that the cultural problem that exists around alcohol must not be ignored as it evidently impacts women’s alcohol consumption during pregnancy, and

how alcohol consumption has become normalised in the UK (Lyons et al., 2006, Measham, 2006) (see Chapter 5). The UK is a 'binge' society where high levels of alcohol consumption are common. The way people drink is therefore important and the wider context needs to be considered. Perhaps the culture of alcohol needs to be changed. The designation of women of childbearing age at risk expounds the message that women seem to be at risk of everything. They are purported to be at risk of being drunk and getting health problems, being vulnerable, being raped, at risk of having unsafe sex and having a baby who itself is then at risk of alcohol-related illness. As Fry (2010, p.1292) argues we therefore need to confront 'the status quo of intoxication as a cultural norm', and create a healthier drinking culture rather than a solely focusing on intoxication and 'high-risk' groups. As ACOG (2005, p.9) argues 'many maternal behaviours are associated with adverse pregnancy outcome, these policies could result in a society in which simply being a woman of reproductive potential could put an individual at risk for criminal prosecution', and I argue that this is true for the way in which abstinence from alcohol is now promoted for all women of childbearing age. The findings of this research indicate that it is not the case that the interests of a pregnant woman and her foetus diverge and that women who drink during pregnancy should not be perceived as a threat to the nation or as threatening the moral order.

It is important that messages which are not backed up through scientific evidence are not being uncritically supported. If women see this message for abstinence as an aspect of control and interference over their lives then they are unlikely to follow it. If the message for abstinence is to be continually supported it needs to be critically examined what this means for health professionals, especially when they are approached by pregnant women who, unaware that they were pregnant, consumed alcohol in their first trimester of their pregnancy and are scared or afraid that they may have caused their baby harm. Will this encourage more women to abort their children for guilt and fear of harm? This message of abstinence could cause excess worry and therefore how we communicate these messages to women when unplanned pregnancies are so high is an important consideration. As Stockwell et al. (2012) argues the abstinence message currently follows a principle of the 'theoretical possibility of harm'.

### **8.7. PROBLEMATIC CONTRADICTIONS AND WHAT MESSAGE SHOULD BE COMMUNICATED TO WOMEN?**

Women who have drunk alcohol whilst pregnant, but before they recognised that they were pregnant, often suffer from guilt and anxiety that they might have caused harm to their foetus. This was revealed through the findings of this study. Tension exists within the healthcare provider's role as it is the doctor's role to reassure women but the impact of a recommendation for abstinence affects the way in which a GP may control and advise women in this situation. It would be inappropriate to advise terminations for women who have drunk before they were aware that they were pregnant but indicating that there is little chance that they have caused their baby harm, then makes it difficult for doctors to tell women to stop drinking during pregnancy. We need to therefore think about harm minimisation and how this advice fits for women preparing for pregnancy. This situation creates a problematic contradiction for how women should be advised when they have already drunk alcohol before they were aware of their pregnancy. Will the recommendation for abstinence produce feelings of shame and anxiety for these women? Also as Leppo and Hecksher (2011) argue, what does this recommendation offer women who are unable to stop drinking alcohol during pregnancy?

Women who may have drunk alcohol before they realised that they are pregnant experience guilt, but is there also an issue of guilt on the behalf of the practitioners? How can these barriers be broken down? It is evident that GPs/Midwives and other health practitioners are still unsure about asking women these 'sensitive' questions around alcohol use. As already argued, because it is a self-reported behaviour and women could feel that they are possibly subject to discrimination and stigmatisation, women are less likely to admit to behaviours which may lead to their being perceived in negative ways and through further medical gaze.

#### ***The Recommendation is aimed at both pregnant and non-pregnant women***

Because the recommendation is aimed at both pregnant and non-pregnant women, it is also designed to alert women who may become pregnant; I will focus on the impact of extending this message to cover all women. Is the message for abstinence during pregnancy linked to the extension in the amounts of alcohol that these groups drink? This has extended the medical gaze as it implies that women should now seek

advice for their health behaviours before their pregnancy; it also extends to all women of reproductive age (Oaks, 2001). The focus on managing health behaviours is therefore shifting from pregnant women to women in the whole. I would argue that this therefore represents an extension of control over women. A similar theme has been found around women who smoke during pregnancy in the work of Graham (1976), Oakley (1989) and Greaves (1996) as the shift has moved from tackling smoking in pregnancy to smoking amongst women in the whole.

‘Abstinence as a health measure has only ever featured for pregnant women. It has never been officially recommended for women as a whole, or for men’ (Waterson, 2000b, p.167) yet the introduction of a recommendation for abstinence in ‘childbearing years’ has the implications of telling women of childbearing age to limit their alcohol consumption in-case of an un-intended pregnancy. Should young women be given guidance and education starting early in primary and secondary schools so they are not drinking heavily before they are pregnant? Sung (2012) recommends that young females who are at risk of becoming pregnant should also be targeted with interventions about alcohol consumption during pregnancy alongside pregnant women, and that ‘at-risk’ drinking needs to be identified.

There is a clear desire by many health departments across the whole of the UK to achieve a high level outcome, of putting in place programmes that reduce maternal alcohol consumption and then onwards into the early childhood period, for example during breastfeeding. This reveals how the reach of surveillance is extending into early motherhood, as drinking when you have a young child is also not a desirable behaviour. The reach is therefore extended beyond pregnancy, for example into how women safeguard their children.

### ***How do we therefore discuss alcohol in pregnancy?***

As alcohol is considered a sensitive topic, it still needs to be examined how it can be approached during pregnancy. As examined in Chapter 4, messages are reliant upon shared knowledge or understanding of what it means to drink, for example alcohol type, units, measures, individual responses to drinking or drinking tolerances. It is evident that the consumption of alcohol is underreported because of stigma but the current tools used to measure women’s alcohol consumption do not seem to be picking up women drinking during pregnancy. I would argue that this idea that



women need to be 'picked up' or 'identified' in itself gives a negative image to surveillance and medical dominance. What is going to be done to help these women when they are identified?

The current audit tools are not very good at picking up women drinking during pregnancy. The shortened version of AUDIT, screening tools of TWEAK and T-ACE for alcohol misuse were recommended for use in the antenatal setting in (Scottish Intercollegiate Guidelines Network, 2004). Brief interventions are well evaluated and empirical evidence shows they work (Nilsen, 2009, O'Connor and Whaley, 2007). Practitioners are also used to these measures, however evidence supporting the use of ABIs (Alcohol Brief Interventions) in the antenatal setting is currently limited and we do not know how useful these measures are for pregnant women. The difficulty in asking pregnant women about their alcohol consumption without building up a relationship has also been recognised (Kaner et al., 1999). A change in culture is needed around pregnancy to ensure that guilt, shame or embarrassment is not felt. This therefore impacts any recommendations or ideas on the screening and recording of women's alcohol consumption during pregnancy. It therefore needs to be evaluated if the audit and questionnaires that are currently used for alcohol work for when trying to discuss alcohol consumption during pregnancy are effective and if these generalised questions truly function to get a true picture of women's alcohol consumption. Some interventions that have been suggested to reduce alcohol consumption during pregnancy such as merconium screening do not seem appropriate. This is partly because this screening goes against the mother and ethical considerations which could also hinder it (Zelner et al., 2012, Marcellus, 2007) but also because it does not assist in women's agency. I would argue, therefore, that this is another form of the medicalisation of motherhood and the testing of mothers to ensure they are complying with health messages. On the other hand, Motivational Interviewing (MI) has been shown to decrease prenatal alcohol consumption (Handmaker et al., 1999). However in their study into the effects of MI, Osterman and Dyehouse (2012) did not find it effective in decreasing prenatal drinking. It has also been used to varying success by researchers within the British Columbia Centre of Excellence for Women's Health (BCCEWH), who recognise the importance ensuring that a women centred approach is used (Drabble et al., 2011, Greaves and Poole, 2005, Reid et al., 2008).

Guidance therefore needs to assess not only how alcohol is discussed during pregnancy but at what point in the pregnancy this discussion takes place and with whom. It has been argued that health professionals have varying reluctance to ask patients a whole range of questions during pregnancy (Ernhart et al., 1988, Payne et al., 2005, Hankin et al., 2000). It is also important how this information is recorded and how it is used to support women. Should messages therefore become more tailored to individual women or should all sources be delivering the same message? The problem of the ‘one size fits all’ approach (as discussed in Chapter 4) is apparent here as how mothers use the process of othering in their choices around alcohol during pregnancy. Some women in this study did other themselves to the message for abstinence, reflecting a general idea that other people are the problem, not themselves. The fluctuation between more permissive messages and a recommendation for total abstinence has facilitated this as it has allowed a discourse of blame and stigmatisation. This idea that ‘other people are the problem and not me’ could however be linked to the fact that women underestimate the amount that they drink as there are difficulties in obtaining accurate drinking histories (Seppä, 2006).

***The idea that we can identify women who are ‘unsafe’ or at ‘high risk’***

A problem exists in interventions dealing with alcohol consumption during pregnancy, and the way in which women use ‘othering’ to legitimise their health behaviour, in the idea that we can easily identify women who are at ‘high risk’ of consumption of alcohol during pregnancy. Handwerker (1994) defines an at risk pregnancy as one where the likelihood of an adverse outcome for the baby or mother is greater than existing risks within the general pregnant population. However Gomberg (1979) argues that whether or not women are at risk of FAS, they become stigmatised by it because of the body of literature existing on it.

It has been shown how the focus on FAS has led to the moral panic over women during pregnancy and the increased medicalisation of women’s bodies. Searle (1996) argues that being labelled ‘at risk’ infers a negative or adverse outcome; however it is also a problematic definition as it has wide implications for the stigmatisation of women and also for the consequences if a woman is unable to change her behaviour. The burden of blame is therefore placed upon the pregnant woman for negative foetal outcomes (Handwerker, 1994). This aligns with the research with pregnant

women into risk by Searle (1996) who found that women expressed the fear of being 'blamed'. As Lupton (1999a) argues the label of 'at-risk' serves to reinforce marginalised or a powerless status, therefore positioning women as vulnerable and particularly dangerous to themselves or their foetus. Another problem with the conception of 'at-risk' pregnancies is how would these labels be applied to women and where would these identifications take place as risk is not necessarily something which can be seen. I would argue that the message for abstinence has not been placed because of women at 'high risk' but instead this problem is about the general population. It is important to remember that it is not illegal to drink during pregnancy; just the same as it is not illegal to smoke. Consequently, the idea of testing women in some physiological way to see if they have consumed alcohol seems derogative and pointless.

Where women (the majority of whom have issues around alcohol dependency) have been penalised for alcohol consumption during pregnancy, I would argue that more should be done to try and help these women and understand why they have problems with alcohol in the first place rather than penalising them and further stigmatising them. As Abel (1999b) considered, only drinkers whose consumption is not dependent will be able to adjust that consumption in response to public education efforts or health campaigns. It could be argued that 'high risk' drinkers are alcoholic women, as it appears to be only very heavy drinking or alcoholism during pregnancy which leads to foetal harm. As observed light drinking is not shown to be problematic (Kelly et al., 2009, Kelly et al., 2010). These women however should already be in reach of services, so the question occurs of how can the opportunities that are already in existence to support women be used? Perhaps this is best to be done in a family and community setting following examples of successful programmes such as 'SheWay' and 'Her Way Home' in Vancouver, Canada, where a women and gender sensitive approach is used. In their work on FASD prevention, CanFASD (2010) argue that it is important that women are informed participants in their own care, and that their autonomy and decision making is supported.

Following this, we have to be careful that we don't liken alcohol use during pregnancy to drug use. More and more, the way alcohol is talked about likens it to an illegal drug, implying that its misuse is the same as for other drugs. Alcohol is not an illegal substance and is a substance that when used in moderation can be used

pleasurably and for socialisation. Many of the women reported in this study doing so. For the women who did recognise that they had an issue with alcohol, they intentionally avoided consuming it, regardless of what the current recommendation was. It needs to be ensured that women who drink alcohol during pregnancy are not treated in the same manner as women drug users. Does the focus therefore need to lie within 'hard to reach groups' or is it that a universal message to all women about the potential harm of drinking during pregnancy is to be communicated?

This debate on public policy challenges what messages women should be given. Should a harm reduction plan be followed or should an abstinence message be maintained from the off as it needs to be recognised that some women may find it difficult to cut out alcohol altogether. This is similar to smoking where some women are advised to keep smoking if they find it too stressful to quit. This is interesting, given that the health implications of smoking during pregnancy are better defined than the impact of moderate drinking during pregnancy.

## **8.8. TIME LAG**

The process of cultural change takes a long time. Other changes, such as the changing attitudes towards drink driving, and the use of seatbelts (Measham, 2006), highlight this. It cannot be expected that women's attitudes towards alcohol consumption during pregnancy will change overnight, from one of low use of alcohol to a view that they should now remain completely abstinent. Women are consumers operating within a society which has been normalised to the (excessive) consumption of alcohol. Perhaps there are some links evident between the time lag in the adaptation to the introduction of seatbelts and the wave of resistance to drink driving within the UK, and the adaption of an abstinence message during pregnancy. A time-lag may therefore exist in the message for abstinence from alcohol in pregnancy being taken up.

We need to be aware that, as with the introduction of health policy, there are always lags in its uptake. It will no doubt take time to adjust behaviour. New information takes time to internalise and as Waterson (2000b) argues specialised medical knowledge gradually permeates general knowledge within time to become part of it. It is also evident that parity can play a large role in these choices that women make. If women have already had one child and followed the medical advice available at

that time that it was reasonable to consume a small amount of alcohol and they had no problems with their child, then asking them to make a further change in their behaviour may be problematic. They may not understand why they need to alter their behaviour if it was previously unproblematic. Public perceptions do change but there is inevitably a lag in this process. Is this indeed an example of a time lag or is it that women are rejecting this notion that they should abstain completely, because they see the recommendation for abstinence in opposition to their own drinking patterns which conform to 'positive drinking'?

Because of the importance of lay knowledge and the reliance on family and peer experiences, the memories of previous generations will therefore impact the uptake of abstinence. If mothers drank, this health behaviour may get passed on to generations. As argued earlier in Chapter 4, pregnant women even used to be encouraged to consume the drink Guinness because of its iron content. Although this is no longer recommended, many people are still aware of this, and this represents an example of how long health recommendations can take to be changed. Women are still aware of this message and it still informs their notions around drinking during pregnancy. Perhaps within time the new recommendation may just become accepted, as it slowly becomes part of the culture of the lives and decisions of women. The smoking ban in the UK could be drawn upon as an example. As Lupton (1999a, p.113) argues 'rather than remaining static, risk positions are often constantly shifting and changing in response to changes in personal experience, local knowledge networks and expert knowledge's'.

## **Chapter 9. Conclusions and Recommendations for Further Studies**

### **9.1. CONCLUSIONS**

This research is interdisciplinary as it draws upon literature from human geography, social policy, public health, sociology and relevant medical literature. The change across departments during my PhD served to add to my knowledge and resulted in this research that deals with and examines how research and theory interconnects around this topic.

This thesis represents the first time women's alcohol consumption during pregnancy has been examined in Scotland since the change to recommend total abstinence from alcohol during pregnancy by The Scottish Government in 2007. Many studies into women and alcohol examine if women are drinking during pregnancy but do not extend our knowledge further by demonstrating an understanding as to why women are continuing to consume alcohol during pregnancy. This research therefore offers an original contribution towards the dominant discourses around alcohol in pregnancy and women's attitudes towards the recommendation for abstinence. The study highlights the importance of women's experience, and the necessity of talking to women to further understand what influences their decision making around alcohol consumption during pregnancy. I have presented a sociological explanation which has furthered current understandings of women's alcohol consumption during pregnancy. There are no claims for a general extension of this research to the population of Scotland as a whole. Instead, I would argue that the in-depth narrative data collected is valuable as it allows researchers to develop a greater understanding of the dominant discourses which women draw upon in their decision-making around maternal alcohol consumption.

My choice to use a health and lifestyle perspective could be seen as a double edged sword as it could have 'softened' my research or 'obscured' the topic and led to people not talking about their alcohol consumption. There is previous evidence within the literature around alcohol that has demonstrated problems in the reliability of self-reporting of alcohol consumption (Jayne et al., 2012a, Graham and Mackinnon, 2010, Stockwell et al., 2012, Stockwell and Room, 2012). It is thought that due to the personal nature of alcohol consumption that women may not give an

accurate description of their alcohol consumption trends, for example, they may exaggerate or play down their actual levels of alcohol consumption. The stigmatisation of alcohol use during pregnancy may affect a women's response as many women are likely to underestimate their alcohol consumption because of this or risk feeling criticised for their lifestyle choices. However my approach worked to situate women's alcohol consumption within a lifestyle perspective, thus highlighting how the issue of alcohol was linked to other issues such as smoking.

By drawing on feminist research by Ettorre (1992), Maynard (1994), McGrath et al. (1993), Oakley (1979), Roberts (1990), Wolf (1996), this research has offered an exploration of women's alcohol consumption during pregnancy in Scotland, primarily women's attitudes towards drinking during pregnancy. It has revealed the importance of the often under-researched pleasure around women's alcohol choices. The women in this study reported consuming alcohol because of the pleasure they gained from it, using it to relax and as a treat during pregnancy. Alcohol was also used for in-group identification, by women as a way to associate with their pre-pregnancy identity. Other women in the study also reported the associated guilt or shame in expectations of them to abstain and this revealed a strong association of the consumption of alcohol during pregnancy and the responsibility of the 'good' mother (Miller, 2005, Phoenix et al., 1991, Lupton and Fenwick, 2001, May, 2008).

This research contributes to our existing knowledge around women's alcohol during pregnancy by highlighting how there are many complex themes involved in women's choices around the choice to drink. My work highlights how the change to abstinence has further led to the messages women receive being inconsistent, which leaves women in a state of confusion. These experiences serve to highlight the way in which women in the UK self-regulate their alcohol consumption during pregnancy. The women in the study showed awareness that by identifying themselves as women who drunk during pregnancy they risk being judged as irresponsible. It is important that we recognise that women have individual and different attitudes towards alcohol, which have been informed by their alcohol career, their family culture and other experiences with which they may have grown up with. Recommendations made to women therefore need to take into account the ways in which alcohol use is socially constructed in Scotland. Any future recommendation made to women should therefore take into account the social nature

of alcohol consumption and the role of positive drinking amongst women's lives, therefore, recognising the significant pleasure which is derived from its use. We therefore need to carefully consider what promotes health-seeking behaviour, and if we are to label women who consume one glass of alcohol during pregnancy as not health-seeking, this will stigmatize women.

The responses to health interventions within this study indicate that there is a further need to evaluate the messages which health professionals are giving to expectant mothers but also the importance of how they are delivered to women on the uptake of them. It also reveals how women have mixed attitudes towards existing public health campaigns and health interventions as they often feel as if they gloss over the individuality of these decisions and the complexity of them within women's lives by the use of a 'one size fits all' approach. Women rejected this through the process of 'othering' (Crawford, 2006), with a general indication that the message for abstinence was only really aimed at very heavy drinkers or alcoholics. This highlighted how public health messages infer that maternal alcohol consumption during pregnancy is a threat to all pregnancies, the moral connotations of this infers that women need to be convinced and educated. This is the message which women are increasingly resistant to. I have also argued how the problematic contradictions of the abstinence message need to be further examined, such as how messages are given to women by health professionals, and that the focus on managing health behaviour is shifting from pregnant women to women as a whole. I would argue that this therefore represents an extension of control over women. This research aligns with the findings of Thompson and Kumar (2011) that people deal with health promotion strategies in different ways. This research reveals women's perception of risk does differ, and the abstinence message fails to recognise it because of its broad 'one size fits all' approach. As Coles et al. (2010) argues managing health has traditionally been a female responsibility, yet these findings reveal that women's autonomy is not respected in their decision making during the consumption of alcohol during pregnancy. It is evident therefore that strong gendered associations with alcohol remain (Hunting and Browne, 2012, Ettorre and Kingdon, 2010). Even though there is still no proven correlation between moderate to low levels of alcohol consumption and harm, instead women's drinking still remains to be viewed as a social problem that needs to be controlled (Ettorre, 1997), not a health choice that



needs to be examined from a women-sensitive standpoint, or a social activity that women may take pleasure from.

There remains a strong emphasis within health guidance on self-regulation, and health is increasingly the responsibility of the individual (Lupton, 1995) yet the recommendation for abstinence has rendered the pregnant body a subject for surveillance. These results reveal how women are not docile bodies. Women do engage with bodies of knowledge however the confusion omitted by the change to a recommendation for abstinence has led to increased reliance on the discourse of lay health.

My research reveals how women are aware of the moral connotations that consuming alcohol during pregnancy may bring, and reveals instances where they were stigmatised for their alcohol consumption. There is already published evidence that this growing emphasis of the concern towards women drinking during pregnancy has come from the extension of the medicalisation of motherhood and pregnancy (Oakley, 1976). In addition the perception that the maternal-foetal relationship is strained and that drinking during pregnancy has become a moral panic (reference). I have argued that messages around alcohol therefore need to engage women rather than construct them as the problem to ensure that women are not victimised if they choose to not follow the advice and continue to drink alcohol during pregnancy. An attempt to trigger concern does not seem appropriate because of the lack of evidence into the risks of even moderate alcohol consumption during pregnancy, a period which is already saturated with risks and concerns.

A central recommendation of this study is therefore the argument that we need to engage women further in these discourses rather than framing them as the problem. Blaming women or stigmatising them for consuming alcohol during pregnancy is unlikely to produce a desired behavioural change. Work therefore needs to be further carried out with women if the message for abstinence from alcohol during pregnancy is to be further promoted. There are various implications of this which are divided into policy/practice implications and recommendations for future research and discussed in turn:

## **9.2. POLICY AND PRACTICE IMPLICATIONS**

One implication of these findings is that women need support, not more education in regards to the consumption of alcohol during pregnancy. This support needs to be tailored to a more individual level and possibly as the finding for the feminisation of wine reveals, it needs to be customised towards particular drinks. This indication that class is an issue in women's alcohol consumption during pregnancy is important as women other themselves to the recommendation, and consequently do not see themselves as the target group for the message for abstinence. Class-based decisions on what type of alcohol to drink are apparent through women's avoidance of certain types of alcohol during pregnancy. Wine was portrayed to be a 'good' type of alcohol to drink if women were to consume alcohol whilst pregnant. Women therefore do not need to be educated about the risks of alcohol in pregnancy or given an accurate account of the risks but need support in other ways.

There are implications of the importance of class to how we frame this issue. The consumption of alcohol is assumed to be far more prevalent in poor areas and, as the findings of this study revealed, is a class issue. Yet actual consumption of alcohol during pregnancy is more prevalent across the middle classes, as evidenced by analysis of the growing up in the Scotland dataset. Yet it is uncontrolled drinking which is continually problematised. There is an evident social issue across the perception that it is the working class or poor women who drink problematically and place their children at risk, in comparison to the idea that middle class families drink more 'safe' alcohol and are not bad mothers. There are implications of these discourses around harm and moral judgements.

The abstinence has implications for how risk is defined in health messages, especially around the consumption of alcohol during pregnancy, as the message for abstinence from alcohol has clearly not engaged women, due to its unclear definition of risk and overwhelming predisposition to a 'one size fits all' recommendation. The results clearly reveal how women do not internalise these messages, as they instead deflect messages as not applicable to them. The findings indicate that women cannot associate with generalised statements about harm and risk. Therefore, women are less likely to take on board these messages and internalise them. There is evidently an inconsistency in the messages given to women but also in how they are given. No

evidence has been put forward to explain why the recommendation has changed to one of abstinence. The change therefore reflects uncertainty amongst policy makers, and the women in this study were perhaps rightfully suspicious of this message for abstinence. Research has indicated that women hold increasing trust in lay knowledge, turning to friends and family for support and information, or also using their own lay knowledge and experience from previous pregnancies, and this needs to be recognised in policy.

This study has helped to further the understanding of the social and cultural context of women's alcohol consumption during pregnancy by confirming the importance of lay health around decision-making. The findings therefore reveal how women desire to be able to make informed decisions about their own health, and this is influential in how we further communicate risk to women. Policy therefore needs to take into account how the importance of lay knowledge can be utilised within public policy to support women better and take into account that women are already potentially bombarded and overloaded with information when they become pregnant. Policy therefore needs to be realistic of the expectations that are made of women and understand what women are feasibly willing to give up during pregnancy. The importance of lay knowledge has been previously recognised (Blaxter, 1997, Davidson et al., 2008, Watkins et al., 2002), however this research highlights that it is especially used during pregnancy. Women in this study challenged the notion of harm and the evidence base behind the guidance, leading to a lack of confidence in the medical profession and an increasing reliance on lay health beliefs.

These findings revealed that the fear of being labelled a 'bad' mother was critical around women's decision-making for the consumption of alcohol during pregnancy. This furthers the existing debate around 'good'/'bad' motherhood as it reveals how these often class-based discourses are important in women's decision making within health choices. It needs to be examined how the fear of being labelled a 'bad' mother and comparisons with class are used to support women in their decisions around alcohol consumption during pregnancy. The results show how women engage with the notion of 'bad' motherhood, whilst resisting these through the class based discourses linked to the feminisation of wine, and its low correlation with harm. This develops our understanding of power as although women are aware of the recommendation for abstinence and discourses that you should avoid drinking during

pregnancy; this message is not being fully absorbed as women still continue to drink. Women instead adjust their behaviour and therefore drink within more private arenas such as the home.

This research highlights the further question of does it matter if women drink a small amount of alcohol in pregnancy? There is no research that indicates a low level of alcohol consumption is correlated with harm to the unborn baby. Women therefore trust their own decision making, which is not surprising given the amount of recommendations that are now given to pregnant women and mothers. This is clearly a period where there are a growing number of rules for women to follow, and therefore there is clear resistance to supporting a message which is not backed up, when they have to already make an excessive number of changes in their life. It must be realised that women are not drinking to put their child at risk. Instead they are making highly informed decisions often through extensive research (including online searches), discussions with health professionals and with peers and family. Policy therefore needs to engage with power and its effect on individual decision-making around health behaviours.

### **9.3. RECOMMENDATIONS FOR FURTHER STUDIES**

As a strong finding from this study was that women recalled messages being given to them in terms of wine, further examination of the literature given to women and the discussions women have with health professionals regarding alcohol consumption during pregnancy needs to be conducted to examine if these recommendations are given to women in terms of wine. It needs to be examined how recommendations can utilise this finding to further engage women within discussions around their alcohol consumption during pregnancy. Work should be done with women to see if they engage better with messages in terms of wine.

This would link in to a further piece of research, examining further how women regard different types of alcohol. This research reveals the way women create a space when discussing their alcohol consumption that allows for them to remain being defined as ‘good’ citizens by positioning them against ‘other’ mothers, often of assumed lower class and less controlled behaviours. A further research project on perceptions of alcohol harm would also be of advantage to general health messages that are given to women around alcohol, as the results of this thesis conclude, women

are still not able to associate their drinking with measurement tools such as units. This has strong implications for women's drinking patterns since measures used when drinking at home far exceed commercial volumes, which is worrying given the increasing consumption of alcohol in off sales and for the home.

A further study could examine how women could be supported further, possibly by the use of family nurse partnerships or enhanced midwifery teams, although it has to be recognised that some women may feel that this is another form of surveillance over them. As revealed by some women in this study, there can sometimes be negative responses towards health visitors, with a feeling that they are checking that women are mothering correctly.

A further analysis of health professionals' own perspectives would complement this research as it is important to listen to how the advice is given by health professionals, in comparison to how it is reported as being received, which the scope of this study did not allow for.

Another related topic of interest would be to further examine the role that partners can bring into helping reduce women's alcohol consumption during pregnancy. Further research could assist in the interviewing of partners to assess the influence which they have within women's choices around alcohol and other related behaviour. Further research would also allow for a deeper understanding of service users perspectives.

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## Appendix 1: Consent Form



### CONSENT FORM

#### Understanding health choices during pregnancy

Researcher: Katharine Ford

1. I confirm that I have read and have understood the information sheet dated 30/04/09 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I give my permission for the research activity to be recorded and transcribed and understand that the all research materials will be anonymised ( no names or identifying personal details will be disclosed) ☐
5. I give my permission for the anonymised transcripts to be deposited into the ESRC data archive for access by wider academic community ☐
6. I hereby assign the copyright in my contribution to the researcher, Katharine Ford ☐
7. I agree to take part in the above study. ☐

_____ Participant Name	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

#### The contact details of lead Researcher (Principal Investigator) are:

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## Appendix 2: Participant Information Sheet



### Understanding health choices during pregnancy Participant Information Sheet Guidelines

*You are invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask me if you would like more information or if there is anything that you do not understand. I would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.*

*Thank you for reading this.*

#### 1. What is the purpose of the study?

This is a study that will be carried out with mothers. It is interested in the health and lifestyle choices that women make before, during and after pregnancy focussing upon exercise, diet, smoking, alcohol consumption, drug use. e.g., to understand what you ate or drank during pregnancy or if you choose to breastfeed. The study is funded by the Economic and Social research council (ESRC) and The Scottish Government, however I would like to stress that I am an independent researcher, i.e., I do not represent the university of Liverpool, The ESRC or the Scottish government.

#### 2. Why have I been chosen to take part?

I am recruiting mothers to take part in the research. In particular I am seeking to speak to mothers with recent experiences of pregnancy and motherhood i.e. women with a child under the age of two.

#### 3. Do I have to take part?

Participation is voluntary and you are free to withdraw at anytime without explanation and without incurring a disadvantage.

#### 4. What will happen if I take part?

The research will involve interviews with Katharine Ford (PhD student at the University of Liverpool). The interviews will take a particular form: I will begin by asking you to talk about your health choices before, during and after pregnancy. This first part of the interview may last from 5 to 55 minutes, depending on how much you have to say and is a good opportunity for you to share your experiences of pregnancy and motherhood. After this I will go back over your life story and ask questions about particular events and what these mean to you. Interviews will last around one hour (though could be longer). It is unlikely but possible that a further session may be required; this would be if we ran out of time in the first interview, or if you felt you had more you wished to talk about.

#### 5. Are there any risks in taking part?

I do not envisage any risks in taking part in the research

#### 6. Are there any benefits in taking part?

You will get the opportunity to talk about your experiences of pregnancy and motherhood and reflect on what these mean to you.

#### 7. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let me know by contacting myself, Katharine Ford on 07756667854 and I will try to help. If you remain unhappy or have a complaint which you feel you cannot come to me with then you should contact the Research Governance Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher involved, and the details of the complaint you wish to make.

**8. Will my participation be kept confidential?**

The interviews will, with your permission, be recorded and transcribed. Copies of the recording and transcriptions will be kept on a password protected university server and only I will have access to these files. All interviews will be anonymised, that means I will change all names and any other identifying information (e.g. where you live, names of schools you have attended). Anonymised transcripts will be retained, and also deposited with the ESRC Data Archive for wider academic use.

**9. Will my taking part be covered by an insurance scheme?**

Participants taking part in a University of Liverpool ethically approved study will have cover.

**10. What will happen to the results of the study?**

I will provide you with copies of transcripts of interviews. I will produce a findings summary that I will make available to all participants and to the Scottish Government. I will use the results in my PhD thesis. If there is an admission to a crime by a participant during an interview, the researcher would be under a legal obligation to report this.

**11. What will happen if I want to stop taking part?**

You can withdraw at anytime, without explanation. Results up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them

**12. Who can I contact if I have further questions?**

Please contact Katharine Ford at:  
Department of Geography  
Roxby Building  
University of Liverpool  
Liverpool L69 7ZT  
Email: [k.ford@liv.ac.uk](mailto:k.ford@liv.ac.uk)  
Tel: 07756667854

**13. CRB check**

For your convenience the researcher will have undergone a CRB police check and will have a Disclosure Scotland certificate that research participants may request to see.

## Appendix 3: Recruitment Letter



Katharine Ford  
The department of Geography  
Roxby Building  
The University of Liverpool  
Liverpool  
L69 7ZT

Mobile: 07756667854  
Email: [K.ford@liv.ac.uk](mailto:K.ford@liv.ac.uk)

Dear Sir/Madam,

I am writing as a PhD researcher at the University of Liverpool looking for volunteers for a study.

I am interested in women's experiences of pregnancy and motherhood, focussing upon lifestyle choices during pregnancy for example, maternal diet, exercise, smoking and alcohol consumption. I am looking for volunteers for interviews; all participants will remain anonymous throughout the research. Volunteers need to be mothers with a child aged two or under.

I enclose a leaflet that contains further details of the study. I would be grateful if you could circulate this to members of your organisation, if you would like more copies of this leaflet I can send some more. I anticipate that this research will be carried out in June 2009, if anyone is interested in participating could you please encourage them to contact me, my contact details are above and are also on the information leaflet. I will follow up this letter with a telephone call within the next week.

Yours faithfully

Katharine Ford

Please note I am funded by the Scottish Government and the ESRC (Economic and Social Research Council) however I am an independent researcher, i.e., I do not represent the views of the University, the ESRC or the Scottish Government.



### **What to expect**

- Professionalism
- Confidentiality
- CRB (Police) check
- Access to transcripts upon request
- Feedback of the overall research results.

at the University of Liverpool on 0151 794 8290.

When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher involved, and the details of the complaint you wish to make



## **Understanding health choices during pregnancy**

### **Volunteers needed!**

Katharine Ford  
PhD Researcher

Department of Geography  
Roxby Building  
University of Liverpool  
L69 7ZT

Mobile: 07756667854  
Email: [k.ford@liv.ac.uk](mailto:k.ford@liv.ac.uk)



### **What if I am unhappy or if there is a problem?**

If you are unhappy, or if there is a problem, please feel free to let me know by contacting me on 07756667854 or by email ([k.ford@liv.ac.uk](mailto:k.ford@liv.ac.uk)) and I will try to help.

If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer ([ethics@liv.ac.uk](mailto:ethics@liv.ac.uk))

### **Invitation to take part**

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information leaflet carefully and feel free to contact me if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends and relatives if you wish.

**You do not have to accept this invitation and should only agree to take part if you want to.**

Thank you for taking your time to read this.

### **What is the purpose of this study?**

I am interested in the health and lifestyle choices that women make during pregnancy, particularly what women choose to eat and drink during pregnancy and after the birth of their child or children.

### **Who can take part?**

If you are a mother with one or more children aged under two years old, then I would like to talk to you. If you have older children as well as one aged under 2 years, then you are still able to take part.

### **Do I have to take part?**

Participation is voluntary and participants are free to withdraw at anytime without explanation and without incurring a disadvantage.

### **What will it involve?**

The main ways that I will gather information will be through interviews and group interviews in an informal setting. All of which will be conducted under the strictest confidence and all the data will be anonymised.

The interviews will vary in length and will involve you talking about your choices during pregnancy, and other lifestyle choices after pregnancy. There will then be some time for answering some other questions based on the same theme.

The data collected will be stored safely in files that only I will have access to.

Following the fieldwork, the anonymised data collected from the research will be used for the write up of my PhD and for academic publications.



## **Appendix 5: Conferences Presented at and Publications**

### **CONFERENCES PRESENTED AT**

Ford, K. The role of pleasure in drinking during pregnancy. BSA Medical Sociology Group 43rd Annual Conference. 14<sup>th</sup> – 16<sup>th</sup> September 2011.

Ford, K. Ethics, methods and researching ‘sensitive’ topics with ‘vulnerable’ groups. 11th Advances in Qualitative Methods (AQM) Conference. 7<sup>th</sup> – 8<sup>th</sup> October 2010. Vancouver, Canada.

Ford, K. Exploring alcohol and pregnancy with women in Scotland. 16th Qualitative Health Research (QHR) conference. 3<sup>rd</sup> – 5<sup>th</sup> October 2010. Vancouver, Canada

Ford, K. Alcohol consumption during pregnancy in Scotland. School of Health Sciences Postgraduate Research Student Conference. 19<sup>th</sup> May 2010. The University of Liverpool.

Ford, K. Alcohol consumption during pregnancy. 67<sup>th</sup> Alcohol Problems Research Symposium, (The Alcohol and health research Unit, UWE). 5<sup>th</sup> November 2009. Kendal

### **PUBLICATIONS**

Ford, K. (2010) Taking a Risk: Exploring Alcohol and Pregnancy with Women in Scotland. INTERNATIONAL JOURNAL OF QUALITATIVE METHODS 9(4):350-351 2010

Ford, K. (2010) Ethics, Methods, and Researching Sensitive Topics with Vulnerable Groups. INTERNATIONAL JOURNAL OF QUALITATIVE METHODS 9(4):442-442 2010

### **Reports:**

Ford, K. (2010) Understanding of the use of alcohol in pregnancy amongst women in Scotland, Third Year Update. Knowledge Transfer Publication Series: Economic and Social Research Council and The Scottish Government Joint PhD Scheme.

Ford, K. (2009) Understanding of the use of alcohol in pregnancy amongst women in Scotland, Second Year Update. Knowledge Transfer Publication Series: Economic and Social Research Council and The Scottish Government Joint PhD Scheme.

Ford, K. (2008) Understanding of the use of alcohol in pregnancy amongst women in Scotland, First Year Update. Knowledge Transfer Publication Series: Economic and Social Research Council and The Scottish Government Joint PhD Scheme.